

Luton and Dunstable University Hospital NHS  
Foundation Trust

# Luton and Dunstable Hospital

## Quality Report

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

### Ratings

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

# Summary of findings

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Luton and Dunstable hospital is part of Luton and Dunstable University Hospital NHS Foundation Trust and it is a medium size acute hospital comprising all acute services. There were approximately 679 beds at this trust including 544 general and acute, 76 maternity and 23 critical care and high dependency beds.

We carried out this inspection as part of our comprehensive inspection programme, which took place during 19 to 21 January 2016. We undertook two unannounced inspections to this hospital on 27 January and 4 February 2016.

We inspected eight core services, and rated three as good overall, being surgery, maternity and gynaecology and end of life care. Three core services were rated as outstanding being urgent and emergency care, children, young people and families and outpatients and diagnostics. Two services, medicine and critical care, were rated as requiring improvement.

We rated the Luton and Dunstable Hospital as good for two of the five key questions for effective and caring. We rated two key questions, responsiveness and well led, as being outstanding. For well led, the hospital had three outstanding ratings, four good ratings and one core service that required improvement; against our aggregation rules this would be rated as good however, during our quality review in order to reflect the positive findings, this was overruled and well led was rated as outstanding. We rated one key question, safety, as requiring improvement. Overall, we rated the hospital as good.

Our key findings were as follows:

- Staff interactions with patients were positive and showed compassion and empathy.
- Feedback from patients was generally very positive.
- Staff morale was generally good and dedication and staff commitment to providing positive outcomes for all patients was high.
- Staff reported incidents appropriately, and learning from incidents was shared effectively.
- Staff we spoke with knew what duty of candour meant for them in practice and was evidenced by the way incidents had been managed.
- Most environments we observed were visibly clean and most staff followed infection control procedures. Equipment had been generally well maintained.
- Safeguarding systems were in place to ensure vulnerable adults and children were protected from abuse and staff followed these procedures.
- Appropriate systems for the storage and handling of medicines were generally in place.
- Nurse staffing levels were variable during the days of the inspection, although in all areas, patients' needs were being met.
- Medical staffing was generally appropriate and there was good emergency cover.
- Working towards providing a seven day service was evident in most areas.
- Patients generally had access to services seven days a week, and were cared for by a multidisciplinary team working in a co-ordinated way.
- Patients' needs were generally assessed and their care and treatment was delivered following local and national guidance for best practice.
- Outcomes for patients were often better than average.
- Pain assessment and management was effective in most areas.
- Most patients' nutritional needs were assessed effectively and met.
- Staff generally had appropriate training to ensure they had the necessary skills and competence to look after patients. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- Services were generally responsive to the needs of patients who used the services.

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- The emergency department consistently met the four hour target for referral, discharge or admission of patients in the emergency department which was recognised at a national level.
- The number of bed moves of more than one was low within the hospital compared to the national average.
- The trust's average length of stay was lower than the England average for elective admissions.
- There was support for vulnerable people, such as people living with dementia and mental health problems.
- We saw there were systems in place to monitor medical outliers effectively throughout the trust.
- We found surgical services were responsive to people's needs and outcomes for patients were good.
- The service regularly carried out operations on a Saturday to meet local need.
- Surgical care and treatment for patient having a fractured neck of femur was comparable to the national average.
- Cancellations of operations were similar to the national average.
- The maternity service held stage two baby friendly accreditation.
- We found there was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service in the children's and young people's service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.
- The specialist palliative care team had a clear vision in place to deliver good quality services and care to patients. There was a long term strategy in place with clear objectives.
- Waiting times for diagnostic procedures was lower than England average.
- The trust consistently met the referral to treatment standards over time.
- There were effective systems for identifying and managing the risks at the team, directorate and organisation levels.
- Generally, there were effective procedures in place for managing complaints.
- There was a strong culture of local team working across most areas we visited.
- Leaders in all services were visible and the majority of staff felt valued and supported.
- The emergency department had an established and experienced leadership team who were visible and approachable to staff at all levels and had a clear and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department.
- Visionary leadership from the Board to all areas of ED resulted in the ownership of the emergency pathway throughout the hospital. The leadership team in ED over the past five years had transformed the service from one of the worst performing ED's in the country, to one of best performing nationally. This significant improvement in performance, despite a continuing rise in year on year attendances, had been recognised at a national level by senior NHS and government leaders.
- The management of risks within services was generally robust and risks had been addressed in a timely manner.

We saw several areas of outstanding practice including:

- The emergency department had a robust process for managing the access and flow in the department which was a multi-disciplinary approach to patient care and had helped to achieve the four hour target consistently since 2012 which was recognised at a national level.
- The dementia nurse specialist for the hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gave staff an experience and insight to what it is like living with dementia and this was very popular and gave staff an understanding of people's individual needs.
- We saw strong, committed leadership from senior management within the surgical division. The senior staff were responsive, supportive, accessible and available to support staff on a day to day basis and during challenging situations.
- Implementation of Super Saturday for elective surgery lists helped to reduce waiting lists. Two separate general surgeons were on call to meet patient needs.
- The hospital had an Endometriosis Regional Centre, which was accredited for advanced endometriosis surgery within the region.
- Paediatric services had developed new models of care for the child in the right place, with the right staff, across tertiary, secondary and primary care boundaries.

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- There were a range of examples of how, as an integrated service, children's services were able to meet the complex needs of children and young people. The level of information given to parents was often in depth and at times complex. Staff managed to communicate with the parents in a way they could understand.
- The neonatal unit had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. The use of innovative ways of working with almost 24 hours a day, seven days a week consultant cover due to the introduction of new consultants and meeting European Working Time Directives had led to the team being able to treat more complex babies.
- There was a range of examples of working collaboratively and the children's and young people's service used innovative and efficient ways to deliver more joined-up care to people who used services. We observed the service prided itself on meeting the transitional needs of young people living with chronic conditions or disabilities through engagement with adult and community services to improve transition from children and young people's services to adult services.
- The outpatients' and diagnostics division had very clear leadership, governance and culture which were used to drive and improve the delivery of quality person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure smooth patient pathway through departments.
- Involvement of clinical staff in the development and design of the orthopaedic hub and breast screening unit have enabled clinical needs to be met and promoted a positive patient experience.
- Joint ward rounds with pharmacy staff and ward based clinicians encouraged shared learning promoting an improved patient experience and possibly improved outcome.

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

- The trust took immediate actions during the inspection to address areas of concern regarding the staffing levels, medicines' management and bed space concerns in the high dependency unit.

In addition, the trust should:

- Ensure that all staff complete mandatory training in line with trust targets, including conflict resolution training.
- Ensure that all relevant staff have the necessary level of safeguarding training.
- Ensure all staff have had an annual appraisal.
- Ensure that information for people who use this service can obtain information in a variety of languages and signage reflects the diversity of the local community.
- Ensure that all services take part in relevant national audits to allow them to be benchmarked amongst their peers and to drive improvements in a timely way.
- Ensure the High Dependency Unit contributes to the Intensive Care National Audit and Research Centre (ICNARC) database, to allow benchmarking against similar services.
- Ensure the time to initial clinical assessment performance information is monitored to give an effective oversight of performance.
- Ensure that all handover documents are completed within the emergency assessment unit.
- Ensure there are consistent processes to enable patients to self-administer their medicines.
- Ensure that there is a standardised consultant led board rounds implemented within the medicine service.
- Ensure that patients receive the recommended input from therapists.
- Ensure environmental repairs are completed in ward areas and kitchen areas.
- Ensure that defined cleaning schedules and standards are in place for all equipment.
- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Ensure patients have their Venous Thromboembolism (VTE) re-assessment 24 hours after admission
- Continue to ensure lessons learnt and actions taken from never events, incidents and complaints are shared across all staff groups.

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- Review the security systems at maternity ward entrances to further improve the safety of women and their babies on the unit.
- Improve the timing of reporting incidents to the National Reporting and Learning System (NRLS).
- Establish parameters for the gynaecology performance dashboard to enable the service to identify areas of compliance that needed addressing.
- Establish appropriate support is available to parents in the maternity unit following the death of their baby.
- Ensure effective collection and oversight of the end of life care service with regards to rapid discharge performance and preferred place of death for patients'.
- Provide adequate waiting area facilities for patient on beds or trolleys within diagnostic areas.
- Provide appropriate facilities to ensure privacy and dignity is maintained for patients who wear gowns for clinical investigations.
- Review plaster technician facilities to ensure appropriate storage and treatment areas are available across the trust.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Outstanding



### Why have we given this rating?

We rated the Emergency Department (ED) within Luton and Dunstable hospital as good overall for safety, effectiveness, and caring. We rated responsiveness and well-led as outstanding. Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and where areas for improvement were identified, this was acted upon. There was a good level of staffing and skill mix for nursing and medical staffing. The department was visibly clean and well organised. There was a good consistent track record on safety and quality performance and staff worked together at all levels to achieve this. Safety of the department was being regularly reviewed through investigating incidents and local audits. The department worked well with other teams internally and externally to improve and achieve good patient outcomes. Patient's care and treatment was delivered in line with current evidence-based guidance and standards, and areas of best practice from external sources were routinely explored. Internal audits were consistently carried out with evidence of continuing improvement. The department exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The trust had been meeting this target annually since February 2012 and was one of the top five performing trusts in the country. We found the service to be caring towards their patients and each other. Patients were treated with dignity and respect and staff were encouraged to challenge behaviour in their colleagues that was not in line with the trust's values. Patients that we spoke to described staff as caring and professional. The service had an established and experienced leadership team who were visible and approachable to staff at all levels and had a clear

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and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department. The department had a clear vision and strategy to continuously improve this service which was recognised at a national level.

## Medical care (including older people's care)

### Requires improvement



Overall, we rated medical care at this hospital to be requiring improvement. Safety within the medical service was rated as requiring improvement. Not all staff adhered to infection control preventions at all times. Infection control training was below the trust target for medical staff. We found inconsistencies in the recording of medicine administration on some wards. We found no process to enable patients to self-administer their medicines, which the service stated was to be addressed. Not all medical staff had had the required level of safeguarding adults and children's training. Many nursing staff had not received their conflict resolution training. Not all venous thromboembolism (VTE) assessments were completed in accordance with trust policy. The service was aware of this concern and was taking actions to improve completion of these assessments and carrying out regular audits. Whilst the service was improving the number of patients that received appropriate antibiotics within one hour for the management of suspected sepsis, not all patients were having appropriate treatment within the specified time. Consultant reviews were inconsistent. The mortality review report for December 2015 recommended a standardisation of consultant ward rounds within the medicine service. On most wards consultants visited their patients every two or three days. Nursing and medical staff had regular mandatory training with the exception of conflict resolution. Although there was a high use of agency, bank and locums in medical and nursing specialities, we found no issues or concern within the staffing levels on the wards visited. We saw good practice regarding the safeguarding of vulnerable adults. Staff took a proactive approach to the early identification of safeguarding concerns. Staff understood their responsibilities to raise concerns and report incidents and near misses. We also

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found that equipment used for patient care was in service date and had been maintained or electrical safety tested. There were systems and processes in place to assess and manage the risks to patients. We judged the effectiveness of this service as requiring improvement because patients were not always receiving effective care and treatment. The Hospital Standardised Mortality ratio (HSMR) was rising above the expected rate; the service was taking a series of actions to understand and address this issue. Outcomes for patients were variable as compared to similar services and where outcomes were below expectations, the service was taking a series of actions to address this.

There was some participation in relevant local and national audits such as national diabetes and the heart failure audit but outcomes were mixed and whilst plans were in place to improve performance, progress was variable. The trust SSNAP data regarding stroke indicated that there were issues with the stroke pathway and the service was taking a series of actions to improve performance indicators. Plans were in place to provide a seven day service, but not all patients were being reviewed by consultants on a daily basis.

The trust had effective evidence based care and treatment policies based on national guidance. Patients' pain was assessed and pain relief provided appropriately. Patients' nutrition and hydration status were assessed and recorded on all the medical wards. We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience. Consent to care and treatment was obtained in line with legislation and guidance and deprivation of liberty was applied appropriately.

We found medicine services to be caring. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients received good care, compassion, dignity and respect. We observed patients received good emotional support.

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We rated the service's responsiveness as good. Access and flow in and out of the medicine services posed problems with delayed discharges identified as an area that required improvement. The referral to treatment time was being achieved and the number of patients being moved between wards was low. Staff understood the procedures regarding complaints. However, they said that any complaint received would firstly be resolved locally. This meant that the outcomes, themes or lessons learnt were not cascaded to staff. Patients' relatives said they were involved and kept informed. There was good awareness of the needs of people living with dementia, learning disability or mental health needs.

We rated the medicine service as good for being well-led. There was a clear vision and strategy for the future of the service. Senior staff and clinicians attended governance meetings. Staff said the recent reconfiguration of the service had improved morale. The staff survey reflected this. Whilst the service had generally recognised the risks to patient safety and progress the quality of care and treatment, actions were not always clearly defined and therefore progress was variable. Learning from mixed performance at national audits was not always effectively used to drive forward improvements in a timely manner.

## Surgery

Good



Overall, we rated surgical services as good. There was a culture of incident reporting and staff said they received feedback and learning from serious incidents. However, not all staff always received feedback on clinical incidents. Staff were able to speak openly about issues and serious incidents.

The environment was visibly clean and generally staff followed the trust policy on infection control, although there was variable completion of cleaning schedules available within some of the wards and theatres.

Medical staffing was appropriate and there were good emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.

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There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts but this was well managed and patients' needs were met at the time of the inspection.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.

Patients outcomes were generally good but not all staff were aware of patients' outcomes relating to national audits or performance measures.

Most staff had received annual appraisals and generally support systems for staff development were effective. Staff had generally completed mandatory training provided by the trust.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures to keep people safe.

The consent process commenced in out-patients and consent was reconfirmed at the time of admission. However, this was not always recorded as the consent form was scanned onto the computer and the confirmation signature could not be added to this electronic form.

Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.

Patient care records were appropriately completed with sufficient detail and kept securely. The service had an effective complaints system in place and learning was evident.

We saw some patients were delayed in recovery following surgery due to lack of beds on the wards and some patients could wait in recovery for four hours. Drinks and snacks were offered during this time.

There was support for people with a learning disability and reasonable adjustments were made to the service. However information leaflets and consent forms were not available in other languages. An interpreting service was available and used.

# Summary of findings

Surgical services were well-led. Senior staff were visible on the wards and theatre areas and staff appreciated this support. There was generally a good awareness amongst staff of the trust's values.

## Critical care

### Requires improvement



Overall, we rated the critical care service as requires improvement.

We found that safe and well-led areas required improvement. However, we rated critical care services good for effective, caring and responsive. We found areas that required improvement, particularly on the high dependency unit (HDU). Medicines were not being safely prescribed and administered on HDU. For example, high risk medicines administered when the prescription was not signed by the prescriber.

The level of nurse to patient ratio on HDU did not meet core standards for critical care services during the initial inspection (Guidelines for the provision of intensive care services (GPICS) 2015). The guidelines stated that the nurse to patient ratio for level two care (high dependency) was one nurse for two patients.

The HDU environment was found to be non-compliant with Department of Health 2013 best practice guidelines for critical care facilities (Health Building Note HBN 04-02) regarding size of bed spaces and provision of hand washing facilities. However, in response to concerns we raised at the time of the inspection, the HDU had undergone urgent reconfiguration and action had been taken to reduce the number of available beds available to 11, while keeping the staffing the same. Following the reconfiguration, we returned during an unannounced inspection and found that the nurse staffing levels met core standards for critical care services (GPICS 2015), there were larger sized bed spaces and medicines were being safely prescribed and administered.

There were also a low number of low or no harm incidents reported by critical care services and a good track record related to incidence of infection. Critical care services were effective. The trust complied with the recommendations within guidance from the National Institute for Health and Care Excellence (NICE guideline 50) for acutely ill patients in hospital.

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Patients' pain scores were being recorded and appropriate pain relief was being provided. Care bundles (evidenced based procedures) were in place for the use of ventilators and central lines (a central venous access device which is a long thin tube inserted into a vein in the chest).

The Intensive care unit (ITU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database and the mortality ratio for the unit was within statistically acceptable limits.

A practice development nurse supported both units with competency completion and induction of new nursing staff.

Patients in the units were required to be screened for delirium using a recognised screening tool (CAM-ICU). However, none of the patients on HDU had been scored for delirium (National Institute for Health and Care Excellence NICE CG83). We raised this with the trust at the time of inspection. All patients had been appropriately assessed when we returned for the unannounced inspection.

HDU did not contribute to the ICNARC database, which meant outcomes were not being benchmarked against similar services. They were unable to meet NICE guidance for rehabilitation of the critically ill patients due to further resources required to increase physiotherapy and follow up clinic provision.

Critical care services were caring. People using the service, including patients and their families were positive about the care and treatment they had received on the critical care units. Staff involved the patients as much as possible in decision making and kept them informed about progress with treatment.

Overall critical care services were responsive to patient's needs. There was provision of facilities for visitors to the ITU, including a waiting room, hot and cold drinks, toilet facilities and a private room, which could be used for discussions.

ITU performed within expected levels for delayed discharges and transferring patients from ITU to a ward overnight when compared with similar units in the ICNARC audit (2014/2015). However, HDU transferred on average 24% of patients to a ward overnight per month (six month period ending December 2015).

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At a unit level there was acknowledgement and reporting of mixed sex occupancy. The trust policy was based on a local agreement with the clinical commissioning group which stated in the majority of cases it may be clinically justified for the patient to remain within the HDU environment if the speciality bed was unavailable to ensure their safety and quality of care. However, the official number of reported breaches for critical care was nil (between April 2014 and December 2015). Translation services were not always accessed for patients who needed them. We found that staff used patients' relatives to translate for staff on HDU.

Critical care services were led by a matron and a clinical lead consultant. The challenges and risks regarding HDU were understood by the leaders. However, actions had not been taken to address these prior to inspection. One of the actions taken, after we raised concerns, was to refocus the leadership for HDU, with the matron taking a senior nurse role until improvements were firmly embedded. The ITU and HDU were not operating as integrated services and had separate rotas, study days, charts and operational policies. There was also a lack of knowledge of the vision for the services demonstrated by staff.

Critical care services had a risk register where risks were documented, reviewed and updated. We also saw evidence of critical care delivery group and directorate meetings being held. Within the minutes of these meetings, we saw that incident reporting, staffing and performance indicators were discussed.

## Maternity and gynaecology

Good



Overall, we rated maternity and gynaecology services as good.

Patients were protected from the risk of avoidable harm and, when concerns were identified, staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary, actions were taken to prevent recurrences.

Environments were visibly clean during the inspection and the service had robust infection control systems in place. Equipment was generally checked regularly and well maintained.

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Medicines were stored and handled safely. Records were completed and stored in accordance with trust policies.

Safeguarding vulnerable adults, children and young people was a priority for the service. We saw staff responded appropriately to signs or allegations of abuse and worked effectively with others to implement protection plans. There was active engagement in local safeguarding procedures and we saw effective work with other relevant organisations during the inspection.

Doctor, nurse and midwife staffing levels and skill mix were planned, implemented and reviewed regularly. Staff shortages were responded to quickly and appropriately. There were effective handovers at shift changes to ensure staff could manage risks to patients.

Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Information about patients' care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Access to medical support was available seven days a week throughout the service.

Feedback about the service and staff was largely positive. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were largely positive. Staff responded compassionately when people needed help and supported them to meet their basic personal needs as and when required. People's privacy and confidentiality was respected.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided.

The service consistently met the 92% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment for gynaecology. Patient flow in the service was generally effective.

Governance arrangements were effective and there was a clearly defined strategy and governance structure in place.

However, we also found that:

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Not all staff had received an appraisal or completed their mandatory training (particularly safeguarding level three) and the trust's target had not been met in all cases. The service had plans in place to address this.

The closed circuit camera system (CCTV) in the maternity block was not appropriate. There was no CCTV at all ward entrances; there were cameras at the entrance to the building. The service was taking action to address this.

Women shared a waiting room for gynaecology and maternity appointments, which was not sensitive to the reasons why women attended their appointments. The service had a plan to address this.

The Supervisor of Midwives (SoM) ratio was worse than the recommendation of 1:15. The service had agreed a local arrangement for enabling the Supervisors of Midwives extra time allocation for work related to Supervision.

Whilst the gynaecology service did have a performance dashboard which monitored a range of outcomes, the newly established gynaecology governance group had not set the parameters for monitoring performance at the time of the inspection. The service was in the process of implementing clear performance measures for the service.

We saw that reporting incidents to the National Reporting and Learning System (NRLS) was not always timely. However, the trust were aware of the issue and improvements had been made as part of the overarching trust wide risk and governance improvement plan.

Information leaflets provided by the termination of pregnancy service were only available in English which did not reflect the diversity of the local population.

## Services for children and young people

Outstanding



Overall, we rated the service as outstanding. We found there was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.

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Treatment and care by all staff was delivered in accordance with best practice and recognised national guidelines.

The service took part in national research programs and used the outcome of these to develop innovative and pioneering approaches to high quality care and monitored the safe use of these new approaches.

The Neonatal unit (NNU) was the lead unit for Hertfordshire and Bedfordshire since 2003 and its high performance was recognised by external bodies.

Both medical and nursing staff we spoke with were passionate about providing a holistic and multidisciplinary approach to assessing, planning and treating patients. This was demonstrated by regular multidisciplinary meetings and excellent communication with their patients and relatives. There was a good track record on safety with lessons learned and improvements made when things went wrong. Staff knew how to report incidents.

Both the paediatric wards and the NNU were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented. Staff felt valued and supported by their managers and received the appropriate training and supervision to enable them to meet patients' individual needs. Senior management had created an environment where staff knew how to raise concerns and follow the duty of candour processes. Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by a range of national audits such as the Royal College of Paediatric Child Health (RCPCH) National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA). The NNU had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and

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cooling therapy which had resulted in a significant reduction in its mortality and morbidity. Staff were very proud about their cooling service which they had developed and continued to deliver.

There was a range of examples of working collaboratively and the service used innovative and efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge, transfer or transition to other services.

Nursing and support staff provided flexibility within the department to provide high quality care that met patients' care needs. Staff were supported to develop and learn new practices. The service had developed and provided courses such as children's assessment knowledge and examination skills (CAKE) courses and STABLE courses for staff which was accessed by external organisations. These had been accredited by the Royal College of Nursing, RCPCH and the local university

There was a clear open, transparent culture which had been established within the leadership team. The service could demonstrate a clear vision and strategy for paediatrics which was led by a strong management team. Staff told us they felt consulted and part of the development of the strategy, they were engaged and enthusiastic about the new developments within the service.

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to developing new approaches to care and treatment.

## End of life care

Good



End of life services were rated as good overall. Patients and relatives all spoke positively about end of life care. Staff provided compassionate care for patients. Services were very responsive to patients' individual needs and those of their families and next of kin.

There were arrangements to minimise risks to patients with measures in place to safeguard adults from abuse, prevent falls, malnutrition and pressure ulcers and, the early identification of a deteriorating patient through the use of an early warning system.

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End of life care followed national guidance and the trust participated in national audits. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

The results of the 2013/14 National Care of the Dying Audit of Hospitals (NCDAH) highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms we inspected were appropriately completed.

Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and their cultural and spiritual needs. The bereavement support staff provided good support to relatives after the death of a patient. The hospital had a rapid discharge service for discharge to a preferred place of care. The trust had not yet completed an audit of patients achieving their preferred place of dying. There was an improvement plan in place for end of life care that was overseen by a strategy steering group. There had been a number of changes put into place in the previous twelve months. These included a new personalised care framework, to replace the discontinued Liverpool Care Pathway, improved rapid discharge processes and the appointment of an end of life care specialist nurse to roll out the new documentation and provide training.

There was evidence of clear leadership in both the palliative care team and at board level. The trust had a clear vision and strategy for end of life care services and participated in regional and locality groups in relation to strategic planning and implementation.

However we found that:

Not all advance care plans patients had made in the community had been reviewed by the hospital's SPCT to ensure they were valid, current and that care and treatment provided was still meeting patients' expressed wishes.

The trust had not completed an audit of patients achieving their preferred place of dying. This meant, because it was not identified, this information could

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not be used to improve or develop services. However, this information was collected by the community team and shared with the trust palliative care team. Access for the trust palliative care CNS team to view PPD (preferred place of death) on the community system had been provided following our inspection. The trust did not collect information of the percentage of patients that had achieved discharge to their preferred place within 24 hours. Without this information they were unable to monitor if they were meeting patients' wishes and how they could make improvements. However, this information was collected by the community team and shared with the trust palliative care team. Access for the trust palliative care CNS team to view PPD (preferred place of death) on the community system had been provided following our inspection.

## Outpatients and diagnostic imaging

Outstanding



Overall, we rated the service as outstanding. Diagnostic services had established a seven day working programme with flexibility of services to provide timely diagnostic procedures for patients. Appointments for both diagnostic services and clinic appointments were flexed according to demands of the service and to meet the individual needs of the patients. The division were working towards increasing outpatient clinics to include evenings and weekends on a routine basis and offered flexibility according to patient condition and any demands on work/life balance. The trust used electronic patient records which provided easy access to results reporting and details of previous contacts with the organisation. This meant that clinicians were well informed of the patients' conditions and could always see the patients with their records available. The division had a proactive approach to developing and training staff. They identified areas where recruitment was difficult and developed their own staff into these roles. This made staff feel valued and invested in, which enhanced retention of posts.

# Summary of findings

Nurse staffing levels were appropriate with minimal vacancies and staffing levels met patient needs at the time of the inspection. Staff in all departments were aware of the actions they should take in the case of a major incident

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Staff had information they needed before providing care and treatment but in a minority of cases, records were not always available in time for clinics.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. Consent was obtained before care and treatment was given.

During the inspection, we saw and were told by patients, that the staff working in outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their treatment. Patients we spoke with during our inspection were positive about the way they were treated.

Waiting times for diagnostic procedures was lower than England average and the trust consistently met the referral to treatment standards over time. There were systems to ensure that services were able to meet individual needs, for example, for people living with dementia. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Staff were familiar with the trust wide vision and values and felt part of the trust as a whole.

Outpatient staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the department.

There were effective systems for identifying and managing the risks associated with outpatient appointments at the team, directorate and organisational levels.

Regular governance meetings were held and staff were updated and involved in the outcomes of these meetings. There was a strong culture of team working across the areas we visited.

# Luton and Dunstable 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 Luton and Dunstable Hospital

Luton and Dunstable University Hospital NHS Foundation Trust provides secondary care services for a population of around 400,000 people within the local catchment area covering Luton, South Bedfordshire and parts of Hertfordshire and Buckinghamshire. It has one main hospital, the Luton and Dunstable Hospital which is a medium size acute hospital comprising all acute services. There were approximately 679 beds at this trust including 544 general and acute, 76 maternity and 23 critical care and high dependency beds. The trust has 4,006 staff (3,561 Whole Time Equivalent or WTE), including 508 WTE medical and dental and 1,150 WTE nursing and midwifery staff. The trust has an annual turnover of £259 million, and in 2014/15 it had a surplus of £65,000.

The trust's main commissioner is Luton Clinical Commissioning Group.

Between January 2015 and December 2015 there were 131,030 A&E attendances at this trust 79,495 inpatient admissions. Of the inpatient admissions, 8,171 were elective and 32,304 were day case and 39,020 were emergency admissions. There were 387,596 outpatient attendances of which 134,637 were first attendances and 252,959 were follow up attendances.

In the latest CQC Intelligent Monitoring report (May 2015), the trust had two risks and one elevated risk. The priority banding for inspection for this trust was 6, and their percentage risk score was 2.1%.

The risks identified were as follows:

- Safeguarding concerns
- GMC – enhanced monitoring

The elevated risk was:

- Composite of hip related PROMS indicators.

The health of people in Luton is varied compare to the England average. Deprivation is higher than average and about 22.4% (10,780) of children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Central Bedfordshire is generally better than the England average. Deprivation is lower than average and the life expectancy for both men and women is higher than the England average.

In Luton 45% of people were of black, Asian and ethnic minorities (BAME) which was higher than the England average. Central Bedfordshire local authority had a much lower BAME ethnicity with 94% of the population being of white ethnicity.

## Our inspection team

Our inspection team was led by

**Chair:** Dr Peter Wilde, BSc, BM, BCh, MRCP, FRCR

# Detailed findings

**Head of Hospital Inspections:** Helen Richardson, Head of Hospitals Inspection, Care Quality Commission

The team included 11 CQC inspectors and a variety of specialists including: medical consultants, senior managers, child and adult safeguarding lead, an

obstetrician, a surgeon, a midwife, end of life care specialists, a paediatrician and paediatric nurse and experts by experience who had experience of using services.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Luton and Dunstable University Hospital NHS Foundation Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges, the Health Overview and scrutiny committee and the local Healthwatch.

We held a listening event in Luton before the inspection, where people shared their views and experiences of services provided by Luton and Dunstable University Hospital NHS Foundation Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection between 19 and 21 January 2016 and two unannounced inspections on the 27 January and 4 February 2016.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, healthcare assistants, student nurses and midwives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from all the departments and clinic areas. We also reviewed the trust's performance data and looked at individual care records. We talked with patients and staff from all the ward areas and outpatients services.

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

## Facts and data about Luton and Dunstable Hospital

Luton and Dunstable Hospital is a medium size acute hospital comprising all acute services.

The trust primarily serves a population of almost 400,000 people within the local catchment area covering Luton, South Bedfordshire and parts of Hertfordshire and Buckinghamshire.

The trust's main commissioner is Luton Clinical Commissioning Group.

The trust has undertaken and continues to progress a significant programme of service and estate reconfiguration. This included the development of a dedicated Orthopaedic centre in November 2015.

Last inspected under the old methodology (with published report) in October 2013. Found to be compliant against six out of eight standards inspected. Found not compliant in outcomes 13 (staffing) and 21 (records).

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	★ Outstanding	★ Outstanding	★ Outstanding
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	★ Outstanding	Good	Good	★ Outstanding	★ Outstanding
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	★ Outstanding	★ Outstanding	★ Outstanding
<b>Overall</b>	Requires improvement	Good	Good	★ Outstanding	★ Outstanding	Good

### Notes

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

# Urgent and emergency services

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Outstanding	
Well-led	Outstanding	
<b>Overall</b>	<b>Outstanding</b>	

## Information about the service

The emergency department (ED) at Luton and Dunstable Hospital provides a 24 hour, seven day a week service to the local population.

The department consists of 10 cubicles for patients within majors, five cubicles within minors and a resuscitation area for up to eight patients.

The department has its own children's ED with a separate waiting area, four cubicles, an observation area and side room, together with dedicated children's resuscitation bay within the main resuscitation 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 Urgent GP Centre which is situated adjacent to the ED.

Between January 2015 and December 2015, the trust had 131,013 Emergency Department attendances. This equates to on average 359 patients per day. Emergency attendances included attendances at the ED at Luton and Dunstable Hospital and attendances streamed to the Urgent GP Centre.

Between April 2014 and March 2015, the trust had 34,888 emergency attendees aged 0-16 years which equates to 25% of all attendees to the ED in that period.

Between April 2015 and August 2015, 20% of attendances resulted in an admission, which is lower than the England average of 22%. The proportion of attendances resulting in admission at this trust has been lower than the England average since 2013/14.

During our inspection, we visited the adult and children's ED. We spoke with 10 patients, 26 members of staff and six ambulance crews and we reviewed 18 sets of patients' records.

We did not visit or rate the Urgent GP Centre as part of this inspection as this service is from an external provider commissioned by the local Clinical Commissioning Group (CCG) and would form part of a separate inspection.

We also carried out an unannounced inspection on 27 January 2016.

# Urgent and emergency services

## Summary of findings

We rated the Emergency Department (ED) within Luton and Dunstable hospital as outstanding overall.

Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.

There was a good level of staffing and skill mix for nursing and medical staffing.

The department was visibly clean and well organised.

There was a good consistent track record on safety and quality performance and staff worked together at all levels to achieve this. Safety of the department was being regularly reviewed through investigating incidents and local audits.

The department worked well with other teams internally and externally to improve and achieve good patient outcomes.

The department exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The trust had been meeting this target annually since February 2012 and was one of the top five performing trusts in the country.

Patient's care and treatment was delivered in line with current evidence-based guidance and standards, and areas of best practice from external sources were routinely explored. Internal audits were consistently carried out with evidence of continuing improvement.

We found the service to be caring towards their patients and each other. Patients were treated with dignity and respect and staff were encouraged to challenge behaviour in their colleagues that was not in line with the trust's values.

Patients that we spoke to described staff as caring and professional.

The service had an established and experienced leadership team who were visible and approachable to staff at all levels and had a clear and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department.

The department had a clear vision and strategy to continuously improve this service which was recognised at a national level.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good



We rated the service overall as good for safety because:

- Incidents were reported appropriately via an electronic system and investigated swiftly with identified learning and improvements made;
- There were clear systems and processes in place to protect children and vulnerable adults from abuse;
- There were systems in place to monitor and improve infection control practices;
- The environment was visibly clean and the equipment was maintained in line with trust policies;
- There were safe systems for the storage and handling of medicines;
- Records were well maintained and kept securely;
- Robust systems were in place to assess and respond to patients' needs;
- Nurse and doctor staffing levels and skill mix were planned in line with guidance on safe staffing in emergency care settings.

However, we found that:

- Children's safeguarding information was recorded electronically on patients' records but was not consistently transcribed onto patients' paper records. However, the medical team did see the information. We spoke to the trust about that at the time of the inspection and received assurances that this was being addressed.
- The department were not meeting the trust's target for staff completing mandatory training. Senior staff told us there had been challenges throughout 2015 to meet mandatory training targets but the department had an action plan in place to address this.

### Incidents

- There was a positive culture towards reporting incidents and nursing, medical and administrative staff understood their responsibilities to raise concerns, record safety incidents and report them both internally and externally.

- Staff in the ED reported patient safety incidents on an electronic system. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- There had been no never events reported for this service between August 2014 and July 2015. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between October 2014 and September 2015, there were 1,776 incidents reported in the service for both adults and children. 83% of incidents reported by staff were related to patients arriving in ED who had community acquired pressure ulcers. Staff told us they are required to report these incidents for monitoring purposes and to aid with discharge plans.
- Of the remaining 295 incidents not related to community acquired pressure ulcers, 33 were specific to children. There were no incidents categorised as major in children. Eleven of the incidents in children's ED related to the usage of the area for extra capacity for adults. The trust had an escalation policy which defined areas of the hospital that could be used as a contingency area when there were bed pressures in the hospital and within this policy were standard operating procedures for each contingency area. Children's ED was one of these areas and there were clear instructions on how to relocate patients in the children's area to the minors' area for adults. Staff told us that they had concerns about this process and had been able to contribute to the development of the escalation policy and felt that their contribution had made it safer. This was highlighted as a risk on the departmental and trust risk register and the trust had plans to increase the capacity of ED to mitigate this risk.
- 262 incidents were specific to adults ED and 184 of these were categorised as low or no harm. 27 of the low or no harm incidents related to mislabelled specimens such as blood samples for patients. These specimens had not been processed as the error was identified and staff had been reminded to check labels and patient details at daily safety briefings. We saw evidence in an ED newsletter that staff had been reminded to double check all patient information before sending the samples for analysis.

# Urgent and emergency services

- Of the remaining low or no harm incidents there were no distinctive themes. 78 incidents reported were categorized as medium or major harm. Eleven of these were related to dispensing or prescribing errors five of which were related to incorrect drug doses with no apparent harm to the patients and we saw evidence that the patients had been told about the errors and staff received feedback. We saw evidence that two incidents relating to intravenous (IV) fluid therapy (this is a process to help maintain the balance of fluid and electrolytes in the body) had been clearly recorded in line with National Institute and Health Care Excellence (NICE) guidance (NICE QS66).
- Three serious incidents were reported to the Strategic Executive Information System (STEIS) between December 2014 and November 2015. Two of these serious incidents were both classed as diagnostic incidents including delay of treatment and one was classed as apparent, actual or suspected self-inflicted harm.
- There was clear evidence that these serious incidents were robustly investigated, improvements were made and learning shared through departmental meetings, newsletters and daily safety briefings. The department had introduced a new mental health assessment tool to help identify patients at risk of harm to themselves and staff that we spoke to at all levels were able to tell us about the improvements made and the incident that it related to.
- Mortality and morbidity rates were discussed at the department's clinical governance meetings in relation to the trust wide strategy to systematically review all deaths. The ED shared the trust wide action plan for reducing mortality. Senior staff attended the mortality board meetings which had representatives from all divisions of the trust.
- The matron's dashboard was compiled monthly and reported key performance indicators which formed a part of the nursing quality dashboard and were discussed at trust wide bi-monthly quality performance meetings. The matron's dashboards displayed findings from incidents during the reported month with evidence of how learning was disseminated to staff and if there was an action plan in place to address areas for improvement which staff were aware of.
- 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 described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm.
- Staff at all levels were able to explain the changes in regulations to Duty of Candour and their responsibility to deliver a timely apology when there was a defined notifiable patient safety incident. There was evidence of people being told when things went wrong via written apologies and local meetings with families and staff involved. The trust had sent information to the homes of each member of staff outlining their responsibilities under this legislation. Staff were openly encouraged to report incidents to encourage learning and improve patient safety.

## Cleanliness, infection control and hygiene

- We saw that the department was visibly clean and all staff carried out cleaning tasks when required.
- Sharps bins (secure boxes for storing used needles and clinical equipment) in all areas of the ED were all dated, clean and not overfilled.
- The department had quality safety boards displayed in staff communal areas highlighting monthly compliance to internal audits for infection control. The quality safety boards contained information which was taken from the matron's dashboard.
- In the Care Quality Commission's 2014 Accident and Emergency (A&E) survey, the service scored 8.2 out of 10 for the question: "In your opinion, how clean was the A&E department?" This was about the same as other trusts.
- The trust undertook an internal infection control audit between July 2015 and September 2015; this included hand hygiene compliance, cannula management and insertions of vascular devices such as central lines to minimise the risk of health care associated illnesses.

## Duty of Candour

# Urgent and emergency services

Each department is required to submit a monthly audit to the trust's infection control team (ICT); the information is collated for all areas and reported quarterly to the Clinical Operations Board. Any scores less than 80% are reported to ICT, Directorate for Infection Prevention Control, Chief Nurse, Matron, General Manager and Clinical Director and an action plan for improvement would be implemented. The audit showed that during this period the ED scored between 85% and 94%.

- On our inspection, we saw that the adult and children's ED had an action plan in place to monitor and improve infection control procedures. This included monthly audits with defined actions if targets were not being met. Staff were encouraged to share best practice with colleagues at all levels by challenging colleagues who were not following trust policy. The result of these departmental audits showed that compliance to hand hygiene between July 2015 and November 2015 ranged between 75% and 88% and for children's ED ranged between 80% and 90%. Staff told us that the design of the department meant that in some areas there were not enough hand washing basins and this was to be addressed in the new design. During our inspection we observed staff wash their hands before and after they treated patients and used hand gel appropriately.
- 'Bare below the elbow' policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment such as gloves and aprons were used as per trust infection control policy.
- We observed good 'barrier nursing', which is a specific set of infection control measures utilised to minimise the risk of a germ spreading to staff or patients.
- We spoke with housekeeping staff whose main role was to assist with the hygiene and cleanliness of the department and they spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed trust infection control policy. We looked at the cleaning stock room and saw that equipment such as coloured mops and buckets were available and stored correctly. The cleaning chemicals all had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.
- We spoke to staff who told us that they had expressed concerns when the trust had recently changed cleaning contractors and there had been some issues around the

provision of appropriate cleaning supplies during the transition period in November 2015. Staff explained that during that period they still had adequate supplies to clean and they had been given the opportunity to discuss concerns with senior staff.

- There were cleaning schedules in place in the department which we saw that staff had signed at regular points throughout the day when they had completed cleaning.
- We saw signs relating to 'hand-washing' techniques above all hand-washing basins and there were sufficient supplies of soap, alcohol gel and hand towels in all appropriate areas.
- The department had a separate room in the resuscitation area which could be utilised for isolation. Staff were able to describe the procedure for use and provided specific examples of when they would use it and there were visual signs for staff and patients when this room was in use.

## Environment and equipment

- There was an on-going programme of redesign and modernisation of facilities at the trust. Previous investment had resulted in increased trolley spaces, creating a dedicated children's ED and refurbishing the decontamination unit in response to Ebola. In addition the relative's room and adjacent viewing room were recently refurbished from charitable funds. It was recognised in the plan that improvements should be made to the size, layout and design of the ED to improve patient flow and experience.
- The hospital building pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments) and we saw evidence that this guidance had been considered in the planning for the new design in line with the trust's overall strategy for improvement.
- The waiting areas were adequate and we did not observe any patients standing whilst waiting to be seen. The current design of the waiting area meant that although staff in reception could see all patients, it was dependent upon where in the reception the staff member was located. The trust had installed visual monitoring equipment so that staff were able to see the

# Urgent and emergency services

waiting area without having to move from their position. This meant that if a patient waiting suddenly deteriorated, staff were able to respond. It also enhanced staff and patient safety.

- Staff in reception sat behind a screened area and had access to panic buttons. Staff were aware of how to raise a security alert and said that they felt safe and security staff were readily available if required.
- There was a clear visual and audio separation between adult and children's ED and this was maintained when there were capacity issues. Children's ED was secure and accessed with staff's individual electronic swipe cards and only relevant staff had access to the department. On our inspection we were issued with visitor's swipe cards and these did not allow us to enter children's ED.
- We saw evidence that the resuscitation trolley in children's ED and the three resuscitation trolleys in adults ED were checked and maintained on a daily and weekly basis and staff were highlighting equipment and drugs that were nearing expiry date. We also saw that in children's ED specific nursing staff had been given the responsibility of making sure these checks were carried out according to trust policy.
- Within the main adult's resuscitation area there was a dedicated resuscitation cubicle for children which was fully equipped.
- Clean stickers were on all resuscitation trolleys and all other equipment we checked was visibly clean with these stickers attached.
- Equipment had been maintained and current portable appliance testing (PAT) labels were on electrical equipment in line with trust policy.
- There was a designated room for patients experiencing mental health related illness. This room was compliant with Royal College of Emergency Medicine (RCEM) guidelines related to caring for patients with mental health illness in emergency departments and was updated as learning from a Serious Incident in 2015 and an on-going audit related to mental health in the ED. We saw that the designated room was positioned next to the nurse's station and had two doors that opened both ways, immovable furniture, panic buttons and no obvious ligature points.
- The ED was located on the ground floor and the computerised tomography scanner (also known as CT or CAT scan) was located on the first floor. Staff told us that this was not ideal and there were plans to address this in the new design for ED.

- The department used a 'floating nurse' or 'transfer nurse' to assist with patients going for tests and diagnostics.

## Medicines

- Medicines were stored in line with trust medicines' management policy and fridge and room temperatures were regularly checked and temperatures recorded.
- Controlled drugs were stored in two separate locked rooms and were accessed with a swipe card. Staff that accessed these rooms were then required to access a locked cupboard using a specific keypad code. We saw that records for controlled drugs were accurate and up to date.
- We reviewed 18 patients' records and found that allergies had been clearly documented in both patients' records and electronic prescribing charts, all charts had been completed as per trust policy.
- We saw that errors with drugs such as incorrect doses given or missed doses were recorded as incidents in line with trust policy and discussed at quarterly trust wide safety meetings.
- We saw that medicines management was discussed regularly at daily safety briefings within the emergency department.
- The department had undertaken quarterly audits throughout 2015 in regards to safe and secure storage of controlled drugs and medicines. The audits highlighted that in February 2015 there were areas for improvement in documentation related to recording CD usage. In November 2015, the recording of this information had significantly improved.

## Records

- 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.
- Paper records used within the department were stored behind the nurses' station and were accessible to staff, when the patient was discharged the paper records were kept in the locked reception area and stored as per trust policy.
- All patients' records that we viewed contained appropriate information that described their care and treatment including observations and diagnostic tests.

# Urgent and emergency services

- Risk assessments for falls and pressure ulcers were recorded appropriately in all records that we looked at.

## Safeguarding

- Across the ED, there was a clear system and process in place for identifying and managing patients at risk of abuse in line with the trust's policy for safeguarding adults and children. Nursing, medical and administrative staff we spoke with were able to explain the process of safeguarding a patient and provide us with specific examples of when they would do this.
- There was clear guidance on recognising signs of specific abuse on display in the ED and who to contact internally and externally with concerns. We saw information relating to Female Genital Mutilation in line with World Health Organisation guidelines. There was specific guidance for caring for patients who presented with suspicious injuries for children and adults.
- The ED had a Child Protection Information Sharing System in place which allowed the trust to share and receive information from other authorities responsible for safeguarding children. When children presented to ED the system generated a specific sign on the patient's records if they had already been identified as 'at risk' or had a specific care plan in place and if they had presented to ED a specified amount of times.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 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' should be trained in safeguarding for children levels one, two and three.
- As of January 2016, all ED nursing staff had the required level for children's safeguarding levels one and two. 71% of nursing staff had completed safeguarding level three for children. All senior medical staff (registrars and above) had received children's safeguarding levels one and two and 45% of medical staff had received safeguarding level three training. The trust's internal target for safeguarding training was 80%. Senior staff told us that delivering safeguarding level three training in 2015 had been challenging due to the unavailability of a suitable trainer. We were told that all relevant staff

had been booked onto the relevant courses to be completed in February 2016. During our inspection the nurse in charge of children's ED on both our announced and unannounced inspections told us they were trained in safeguarding level three.

- The trust told us that all band 7 nurses in the ED had received safeguarding level three training. This meant that on every shift a senior member of staff was on duty with the appropriate safeguarding competencies in line with national guidance set out by the Royal College of Paediatrics and Child Health (RCPCH 2014). This was checked by the matron at monthly sign off of the rotas.
- On our unannounced inspection, we looked at eight sets of paper records, five of which were children's. We noticed that the mandatory field for safeguarding had not been completed by medical staff on each of these records. We spoke with staff who advised us that this field should be completed for each record. Children's safeguarding information was being recorded electronically on patients' records but was not consistently transcribed onto patients' paper records. However, the medical team did see the information. We highlighted this to the trust and we were told that this would be reviewed immediately. We received an update from the trust immediately after our inspection which showed that they had undertaken an audit of records from December 2015. 10 sets of children's records had been checked and in all cases the mandatory safeguarding field had been completed in either the paper records or on the electronic system. We were told that correct documentation would be discussed at medical handovers and that this would be reviewed again in three months' time.

## Mandatory training

- Mandatory training consisted of fire safety awareness, infection control, information governance, safe manual handling, adult and children's safeguarding (levels one and two). Courses for mandatory training were online and face-to-face teaching lessons.
- The trust's target for mandatory training was 80%. Over 90% of adults and children's ED nursing staff had up to date training in all the mandatory training modules, except for conflict resolution (only 47% of nursing staff had completed this module).

# Urgent and emergency services

- Medical staff had met the trust 80% target for staff trained in adult safeguarding and children's levels one and two. 64% were compliant with fire safety, infection control and safe manual handling and 50% were compliant with information governance.
- 100% of junior medical staff and 91% of nursing staff were trained in basic life support (BLS). 88% of senior medical staff (consultants and registrars ST3 level and above) were trained in advanced life support (ALS) for adults and 49% of junior medical staff and 68% of nursing staff had also received this training. 79% of senior medical staff, 18% of junior medical staff and 63% of nursing staff had received paediatric life support (PLS) training. National guidelines recommend that all emergency department nursing and medical staff should be PLS or equivalent trained.
- Senior staff told us that there were plans to deliver bespoke training sessions for ED staff and plans to allow staff time to complete specific training. During our inspection we spoke to nursing staff who told us that they had been given time during their shift to complete mandatory training and saw evidence that training needs had been discussed in clinical governance meetings, senior staff were able to verbalise their strategy to address training needs but we saw no clear action plan. After the inspection, we asked for their plan and the department submitted an action plan with clear targets and review dates.

## Assessing and responding to patient risk

- All patients booked into the ED received a full, appropriate triage based upon their presentation, which was undertaken by an appropriately qualified registered nurse 24 hours a day, seven days week. The triage system used within the ED was based on the Manchester Triage System (MTS) and the service told us it went above and beyond the observations required by the MTS. The triage system was in line with all Royal College of Emergency Medicine (RCEM) Guidance.
- From 8.30am to 11pm, patients self-presenting to ED were seen by a streaming nurse (band 6 or above) in reception. A brief description of the patient's condition was taken and the patient was then booked in on the ED computer system and given a slip of paper with their complaint description and the area of ED that they would be seen in. During this process patients spoke to staff at a window which had partial screens at either side; this allowed some privacy. The streaming role was carried out by an Emergency Nurse Practitioner (ENP) who had extra training and competencies or a registered nurse (Band 5 or 6) with triage competencies at all other times.
- Patients were streamed to either majors, minors, resuscitation area, children's ED or the Urgent GP Centre, and once a patient arrived at their designated area they would receive their first assessment by a clinician. There were specific pathways for streaming in place to enhance patient care and safety and no children aged 0-6 months were streamed to the GP service. If a patient presented to the ED with priority symptoms such as chest pain or breathing difficulties they would be prioritised and sent straight to majors where they would receive an initial assessment.
- Following allocation by the streaming nurse to one of the ED streams (minors/majors/resuscitation/children's ED), all patients received a full triage assessment from an appropriate skilled nurse. The specifics of the triage was dependent on the care stream to which the patient was allocated. For patients' streamed to majors, the service aimed to triage all patients within 20 minutes of presentation. If the wait to triage reached 30 minutes, the triage nurse escalated to the nurse in charge who then allocated another nurse to open an additional triage cubicle. Patients streamed to resuscitation would be triaged immediately. All patients streamed to children's ED were triaged within 15 minutes.
- Outside of these hours the receptionist would allocate patients into adult or children's ED to be triaged by a registered nurse. Any patient whom the receptionist was concerned about was escalated immediately to the triage nurse who also monitored the waiting area. The nurse in charge of the ED was able to monitor patients in the waiting room via a video link.
- In addition to this 'ED Rounding' took place every hour, 24 hours a day. This involved a nurse or healthcare assistant reviewing the patients in the waiting area to ensure they were comfortable. During this period, patients were not necessarily seen in order of presentation, but in order of severity of presenting condition. This was determined by the triage nurse who was able to see the presenting complaint of every patient in the department. At no times did receptionists make any clinical judgements. At all times, patients presenting with chest pain or shortness of breath were immediately moved to the front of the triage queue.

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- The trust had in place a two tier clinical assessment for the process for receiving patients conveyed by ambulance.
- In the tier one assessment, patients received their initial clinical assessment as soon as they are brought into the department in order that the nurse in charge could assess which area (resuscitation/majors/minors) the patient was to be managed in and the priority which that patient needed to be given. This process included: patient history; blood pressure; pulse; temperature; respiration rate; oxygen saturation; allergies; pain score; Glasgow Coma Scale and was in keeping with the Department of Health's (DoH) definition of initial assessment. This assessment took place as soon as an ambulance conveying patient arrived in the department and was entered into the department's electronic system. Patients were booked onto the system immediately or within 15 minutes of the ambulance wheel stop time and was in keeping with DoH guidance on the reception of ambulance conveyed patients:
- In the tier two assessments, following the initial triage clinical assessment, a further clinical assessment was undertaken. This assessment included the first line diagnostic tests. This process was time-stamped within the department's electronic system and was the source of the 'time for initial clinical assessment' indicator. However, the trust told us that this in reality was the time for the second assessment.
- In the department's weekly dashboard for the week ending 25 October 2015, the weekly figure for minutes to initial assessment (95th percentile) was 25 minutes, which was above the trust target of less than 15 minutes. This time to initial clinical assessment related to patients conveyed to hospital by ambulance and this was calculated at the 95th percentile and is not the average time to initial clinical assessment. We spoke to senior staff about this and they told us that there had been some issues surrounding the IT system they were using to record this data, this had been highlighted to the trust board and there were plans to change the system in line with the trust wide improvement plan. We also saw evidence of discussions about having a qualified nurse to conduct triage at reception. This was on the risk register.
- Between August 2013 and September 2015, the ambulance arrival time to initial assessment was between six and twelve minutes which was consistently worse than the England average of between three and six minutes. We asked staff about this and observed the handover from three patients arriving at the ED by ambulance. The ambulance crews accessed the department via a dedicated door which led straight into the majors' area. The ambulance crew gave a handover to an ED nurse who then found the patient a bay and recorded an initial clinical assessment. The ambulance crew then went out to the ED reception and booked the patient in. The clock stops for ambulance handover once the patient had been booked in at the reception. We observed delays of seven to 10 minutes between ambulances handing the patient over to ED staff and booking the patient into reception. Staff suggested that this issue could be minimised by having a receptionist based in the majors' area. This was a fairly new idea and senior staff told us that they were considering this option, we saw evidence of this in minutes from departmental meetings and this was on the departmental and trust wide risk register.
- We tracked the journey of 14 patients through the ED from the time of their arrival until they were discharged from the department. Of those 14 patients, 11 received a clinical assessment within 15 minutes of their arrival at the ED this ranged from two to 14 minutes. The other three patients received a clinical assessment at 30 minutes, 18 minutes and 17 minutes, respectively.
- In the department's weekly dashboard for the week ending 25 October 2015, the weekly figure for minutes to treatment decision was 47 minutes, which was better than the trust target of less than 60 minutes. The service consistently met this target over time.
- The service was recording the time to initial clinical assessment for all patients, but there was not an effective monitoring system in place giving oversight into the overall departmental performance.
- A colour coded Early Warning System (EWS) was used in adults ED and a Paediatric Early Warning System 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 saw evidence of this on our inspection when reviewing patient's records and evidence of escalation when necessary.
- In June 2015, the department undertook a sepsis audit using the sepsis six care bundle (this is six steps to

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managing patients suspected of having severe sepsis or sepsis shock). One of these steps is administration of intravenous antibiotics within one hour of presentation. In the June 2015 audit 50% of patients received antibiotics within the hour and 90% of patients within two hours. This was highlighted as an area for improvement particularly around documenting time that antibiotics were administered (as the audit showed that this was not always being completed) and further audits were conducted between September and December 2015 with compliance to antibiotics administration at 71% in November 2015. The department had on-going plans to continue to audit and improve the management of patients with severe sepsis.

- The department had clear guidance on escalation procedures for deteriorating patients which was attached to the observation chart. The guidance described the increase in observations that must be taken when a patient's condition showed signs of deterioration on the chart and when to escalate to a senior clinician.
- As part of the initial assessment in children's ED, a pain assessment tool was used and the score was recorded on all children's records that we viewed.
- There was no Clinical Decision Unit (CDU) within ED; however, the function was available on the adjacent Emergency Assessment Unit (EAU). The ED had clear pathways to send patients to the Emergency Assessment Unit (EAU) and the ED consultants had access to up to four beds on the unit to manage patients that met the criteria. This included patients who needed a period of observation or who were awaiting test results before a decision to admit or discharge could be made.

## Nursing staffing

- We observed in adults and children's ED during the announced and unannounced inspections that there was a good skill mix and level of nursing staffing that met patients' needs.
- There were no junior nursing staff working without supervision and senior nursing staff were visible or available at all times.
- The Royal College of Nursing (RCN) guidelines recommend the following ratios for safer staffing in EDs based on acuity levels of patients: low dependency

requires one nurse to 3.5 patients, total and moderate dependency patients require one nurse to two patients and high dependency patients require one to one nursing.

- The department used the Baseline Emergency Staffing Tool (BEST) to inform nursing staffing decisions. This tool was designed by the RCN to assist EDs to estimate their nursing staff requirements based on historical data. Senior staff told us a daily risk assessment was carried out by the matron and senior nurse to ensure staffing numbers and skill mix were appropriate at all times.
- Based on these guidelines, the ED planned staffing during the day time was three registered nurses (RGN) for ten majors cubicles plus one band 7 triage/supervisory nurse and a health care assistant (HCA). There was also five RGNs for eight resuscitation spaces and two emergency nurse practitioners (ENP) plus one HCA in minors until midnight and a floating/transfer nurse to assist with patients going for tests and diagnostics. The planned staffing during the night was the same for majors but with one extra HCA and staffing in resuscitation was the same as day time.
- On our unannounced inspection during the night there were 10 registered nurses on duty in the adult ED, there was also an ENP and two HCAs. Four RGNs were looking after six patients in the resuscitation area, three RGNs were looking after patients in majors' cubicles, one RGN and one ENP were looking after patients in the minors' area, one RGN was streaming, one RGN was in triage and there were two HCAs on duty. These ratios were in line with current guidelines and staff told us that they were up to establishment for nursing staffing.
- Nursing staff handovers were structured and involved staff that were starting and finishing their shifts in a group meeting (nursing staff representatives from night and day shifts) 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.
- The RCN guidelines for staffing in children's ED states there should be a minimum of two registered children's nurses available at all times for this type of unit. The planned daytime staffing was three registered children's nurses (RSCN) and an HCA, plus one supernumerary band 7 ward manager and an ENP for minor injuries for children was planned for 11.5 hours five days a week.

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The planned staffing for night time was two RSCNs for six cubicles. On our unannounced inspection there were two RSCNs and a nursery nurse on duty during the night, these ratios were in line with national guidance for staffing in children's ED.

- The nursing vacancy rate in December 2015 was 8.5% this is the equivalent of one registered nurse per day. The department had arrangements in place for these shifts to be covered by agency and bank staff (staff already employed by the trust who took on extra shifts). Agency and bank staff received an induction which covered 19 specific areas including access to the IT systems, governance, safeguarding adults and children. On our unannounced inspection there was one regular agency staff on duty in adult's ED and they had had their induction with the nurse in charge. In children's ED, staff told us that they were over establishment by 0.6 whole time equivalent (WTE) and that they used regular agency and bank staff to cover sickness and annual leave. The children's ED also had a system which was managed by the ED ward manager which allowed staff to 'swap' shifts with colleagues of equivalent level within the department to minimise the usage of bank and agency staff.

## Medical staffing

- The RCEM recommend that all EDs should have consultant presence for a minimum of 16 hours a day. Consultant cover was provided seven days a week between 8am and 12pm. Outside of these hours the team was led by a specialist registrar (ST4 and above or senior clinical fellow) with on-call consultant cover available after 12pm. The department was met the 16 hour minimum consultant presence and part of the overall strategy for the department was to work towards a 24 hour seven day a week consultant-led department.
- The department had funded posts for 10 whole time equivalent (WTE) consultants as per national recommendations. At the time of our inspection, there was one vacancy for a consultant and this post was being covered long term by a locum who had received a comprehensive induction.
- National guidelines for emergency departments seeing 16000+ children a year state that there should be at least one consultant with sub-specialist training in children's emergency medicine. The department had

two dual accredited consultants with specific training in children's emergency medicine (PEM) and three consultants had specific competencies and training in children's emergency care.

- The medical vacancy rate in December 2015 was 28%; this was mainly due to a shortage of junior doctors as the department had a higher level of middle grade doctors than the national average and only one vacancy for a consultant which was covered by locum doctors. The department had an on-going plan to recruit medical staff and this was highlighted on their risk register.
- Locums were used long term to cover vacant posts and were incorporated into the rota. The department had a comprehensive induction policy for bank, agency and locum staff. Ad hoc locums and agency staff were used to cover annual leave, sickness and study leave.
- On our unannounced inspection, we arrived at the department at 8.15pm, and there was a consultant on duty until midnight with eight other medical staff on duty. The lead doctor after midnight was a senior registrar (ST5 level).
- We observed a morning handover for medical staff which was well structured and concise. During the handover, we observed that junior and senior staff discussed the acuity levels of patients to prioritise care and treatment and discussed infection control procedures.

## Major incident awareness and training

- The department had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents.
- We saw evidence of participation in multi-disciplinary local table top major incident exercises incorporating the proximity of the trust to the local airport.
- Internal exercises were carried out with learning points highlighted. For example, we saw evidence of an internal table top exercise related to telephony and communication when a major incident was declared. We saw evidence that issues had been identified and an action plan completed. We were told that learning from these incidents was disseminated through departmental meetings and newsletters.
- We were told that 92% of nursing staff had received major incident training, 22% of consultants, 33% of registrars and 41% of junior medical staff. There was an action plan in place to address this which included

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ensuring that staff had completed online modules through review at appraisals and designing an ED specific training programme. We saw the Emergency Preparedness Resilience and Response (EPRR) calendar for 2015 which offered training sessions for all staff throughout the year and saw that there were regular training sessions for ED. Mandatory and extra sessions were held for all ED staff including bank and agency staff.

- The department had a dedicated decontamination unit with separate access to that of the main ED reception. This unit could be used to manage patients who may have been exposed to chemical, biological, radiological and nuclear (CBRN) materials and needed to be isolated and undergo a specific decontamination process.
- The decontamination unit was clean and well organised, and equipment and drugs were checked and sealed on a regular basis
- We spoke with staff who were aware of the major incident plan and spoke of the usefulness of this when dealing with cases of suspected Viral Haemorrhagic Fever (VHF).
- Some staff told us that they had undergone extensive training related to Ebola including comprehensive training regarding PPE (known as ‘doffing and donning’) and managing the suspected Ebola patient.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Overall, we rated the service good in effectiveness because:

- Care and treatment was delivered in line with national guidance and best practice;
- The department conducted regular audits and participated in peer reviews to monitor and improve ways of working;
- Technology was utilised to enhance care and treatment;
- Multi-disciplinary team working to achieve good patient outcomes was good both internally and externally;
- Staff had good understanding of the consent process and the relevant legislation and guidelines relating to adults and children;

- Training needs were identified through supervision, appraisal and one-to-one meetings.

However we found that:

- The target for appraisal rates was not being met and the department had plans in place to address this issue which included further development of their preceptorship programme;
- Whilst the department had gathered data for national audits in the past three years, twice this data was not submitted. However, the trust undertook a benchmarking exercise to compare the service’s performance against both the Royal College of Emergency Medicine standards and against the national outcomes and put plans in place to drive improvements.

## Evidence-based care and treatment

- We saw evidence that care was delivered in line with recommended national guidance for emergency departments and medicine. This included specific pathways for patients presenting with head injuries, sepsis and fractured neck of femur.
- The department used the ‘sepsis six’ care bundle and active cancer sepsis care bundle pathways in line with NICE guidelines 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 were conducting regular audits.
- The service met the minimum requirements for units which see the less seriously ill or injured as outlined by the RCEM. This guidance refers to units that deliver urgent care services such as treatment for minor injuries and relates to competencies of healthcare professionals, clear pathways for care and treatment and access to emergency facilities.
- The children’s ED were using pathways of care for children presenting to ED including acute abdominal pain and exacerbated asthma in line with RCEM guidelines.
- The ED had a mechanical cardiopulmonary resuscitation (CPR) device in which a battery-powered load-distributing chest band provided automated

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compressions. It is designed to provide consistent CPR over long periods of time and recommended by the Resuscitation Council (UK) for situations when sustained high quality manual compressions are required.

- We spoke with nursing and medical staff who had a good understanding of the Mental Health Act 1983 (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder and if they required treatment for a physical illness consent would still have to be sought in line with current legislation.

## Pain relief

- In the CQC's 2014 A&E survey, the service scored 4.9 out of 10 for the question: "How many minutes after you requested pain relief medication did it take before you got it?" and scored 7.4 out of 10 for the question: "Do you think that the hospital did everything they could to help control your pain?". Both scores were about same as for other trusts.
- The ED had a pain scoring tool which was used to record the patients' level of pain. Adult patients were asked what their pain score was from 0-10. We did not see any evidence of regular audits for adults, however, monthly pain audits were part of the overarching nursing audit programme. In response to the Friends and Family Test (FFT), an action plan to improve patient experience had been implemented and this included pain management within initial assessments.
- The children's ED had a visual pain assessment tool which is in line with RCEM guidelines. We saw evidence of regular audits throughout 2015 with identified learning outcomes and improvements. The children's ED used stickers on patient's records to show the level of pain the patient was experiencing; we saw evidence of this on the eight children's records that we looked at. The children's pain assessment tool used throughout the trust had been developed by staff in the children's ED.
- The department had posters reminding staff to ask about pain and also in the waiting and reception area advising patients to tell staff if they were in pain. All the patients we spoke to said that they had been asked about their pain and given pain relief.

## Nutrition and hydration

- We spoke with housekeeping staff who stated that they did their best to offer healthy options to patients.

- Reception, nursing and housekeeping staff carried out hourly checks for patients waiting to be seen and those waiting to be admitted and offered refreshments when appropriate.
- We spoke with patients who said that they had been asked about and received refreshments.
- We saw evidence on patient's records that fluid and food intake had been 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.

## Patient outcomes

- The Royal College of Emergency Medicine (RCEM) invites emergency departments to take part in national clinical audits annually which evaluate care based against agreed standards. In 2014/2015, the RCEM conducted clinical audits relating to the initial management of fitting children, mental health in the ED and assessing for cognitive impairment in older people.
- In 2013/2014, the trust completed the RCEM audit, however, was not in a position to submit the data before the RCEM deadline so the ED team completed the audits and benchmarked themselves against the RCEM standards. The Board was fully aware of the position and it was reported formally in the trust's Quality Account. For 2014/2015, In 2014/15 the RCEM audits were completed however the data was not submitted to the RCEM team because the submission date was overlooked at a time when the department's focus was on managing unprecedented demand and during extensive rebuilding work in the department. However, in both 2013/14 and 2014/15, the trust received the RCEM audit reports and undertook a benchmarking exercise to compare the service's performance against both the RCEM standards and against the national outcomes. In 2015/16 the service successfully registered, undertook and submitted the audit data.
- The department used the data from the audits and based on national guidance made improvements to the way they delivered care. A new mental health assessment tool was introduced based on national guidance and a dedicated mental health assessment room in ED was modified to meet national requirements set by RCEM. Medical and nursing staff we spoke with who had been involved in this audit were positive about how the results of the audit had led to improvements in care and patient safety.

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- The Commissioning and Quality Innovation (CQUIN) framework supports improvements in quality and patterns of care in specific identified areas of care and treatment. In order to achieve CQUINs, the service provider must submit evidence that they are meeting the requirements on a quarterly basis. The ED had three CQUINs for 2015/16 and they were meeting the quarterly targets, these were: sepsis screening and sepsis antibiotic administration, reducing the proportion of avoidable emergency admissions to hospital and improving re-attendance rates of patients with mental health needs at ED and remodelling of clinical navigation pathway, including end of life care. We saw evidence of audits undertaken and the improvements and changes to practice made as a result.
- The service conducted a number of internal audits including pain management in children's ED. Between April 2015 and October 2015, results of these pain management audits showed that the median time for pain relief to be administered to children had improved from an average of forty three minutes to eleven minutes, which is in line with RCEM guidance.
- From October 2014 to September 2015, the unplanned re-attendance rate to the emergency department within seven days of discharge ranged between 5% and 7%. This was consistently lower than the England average of above 7% but higher than the national standard of 5%. As a result of the CQUIN related to improving attendance rates of patients with mental health needs, the service had developed pathways with external providers with agreed targets for continuous improvement in this area. We saw evidence in ED governance meeting minutes that the reduction of re-attendance rates was discussed and a plan for auditing and improving had been agreed.
- 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'. The conditions are: adults (over 17 years old) with non-traumatic chest pain, febrile children under 12 months and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge from the ED. We spoke with medical staff in ED who confirmed that they do this for adults with non-traumatic chest pain and the patient making an unscheduled return within 72 hours, but not always for febrile children under 12 months. We asked the trust about this and we were provided with evidence that showed that the department had an action plan in place to re-audit this practice as part of their audit plan for 2015/2016. We saw that in 2011, the department had participated in the voluntary RCEM audit for 'consultant sign-off' which showed that at that time no patients were seen by ED consultants on weekends and the percentage of patients overall that were seen by a consultant prior to discharge was less than the national average of 12%. The recommendation was that the department increase consultant numbers to 10, in line with RCEM guidelines and re-audit when that standard was met, this standard was met in March 2015.
- We saw that the trust had conducted an audit between August and October 2014 related to paracetamol overdose and adherence to national treatment guidelines set out by the Human Medicines Regulations (2012). This was also referenced to RCEM standards to allow benchmarking. The results of the audit showed that the ED was 92-100% compliant with standards including measurement of plasma levels and treatment times for staggered overdoses. We saw an action plan related to the audit which was re-planned for 2016.
- We were told by the trust that an audit of asthma in children using RCEM standards was underway and due for completion in August 2016. The results of the audit were not available at the time of our inspection.
- The department joined the East of England Trauma Network (EETN) as a major trauma unit in 2014. 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. We saw evidence of improvements made to the CT arrangements and also the pathway for patients with head injuries after the department received feedback from a peer review which was conducted in February 2015.
- In 2015, the department conducted an audit related to renal colic to improve care and treatment for patients presenting with acute abdominal pain based on RCEM guidelines. The results showed that patients were receiving pain relief in a timely manner and care plans

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were being completed appropriately. Areas for improvement included appropriate diagnostics and documentation prior to discharge; the audit was on-going.

## Competent staff

- As of 20 January 2016, 86% of all staff in ED had received an up to date appraisal slightly below the trust's target of 90%. Broken down, this equated to 92% of children's nursing staff had up to date appraisals, 77% of adult nursing staff had received appraisals and 81% of medical staff had up to date appraisals. The department had introduced a preceptorship programme to improve appraisal rates and also to provide development for senior nurses.
- We were told by staff that training and developmental needs were discussed at annual appraisals and 1:1 meetings were arranged ad hoc to address any areas for immediate improvement.
- A senior member of staff in both adults and children's ED was the lead for developing training opportunities for nursing staff. We saw evidence of courses being arranged for specific areas such as trauma management. Adult nurses were routinely being rotated in children's ED under supervision to improve their skills and strengthen the workforce.
- Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 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 are, how to register online and directing staff to speak to senior staff if they had any questions or concerns.
- Medical staff have been required to undergo a revalidation process with the General Medical Council (GMC) since 2012. Nine consultants in the ED had revalidated and out of 13 middle grade doctors, six had completed revalidation and seven were working towards this in line with timelines set out by the GMC. The trust had a process in place to support medical staff in revalidation procedures.

## Multidisciplinary working

- We observed effective communication between nursing and medical teams at their separate handovers at

change of shifts. Staff discussed risks and patient safety including acuity levels of patients. We saw that staff at all levels within both the nursing and medical teams were encouraged to contribute.

- We saw evidence that the department had been working closely with external providers and commissioners to improve pathways of care for mental health patients. Staff told us that they had developed good working relationships with external and internal teams.
- The department had a psychiatric liaison team which they had access to 24 hours, 7 days a week. This was a new external provider and we saw evidence of how the department had worked with them to improve the facilities and services for patients with mental health illness.
- We spoke with the clinical navigation nurse and integrated discharge team who worked closely with the ED to help reduce avoidable admissions by identifying patients that would benefit from receiving their care and treatment in the community.
- The ED had a dedicated stroke nurse who provided a liaison between the stroke ward and the department.
- The department had a close working relationship with the EAU and had agreed criteria for pathways for patients who needed a defined period of monitoring or care before discharge or admission.
- We saw minutes from meetings regarding the streaming to the Urgent GP Centre and saw where changes were made as a result of feedback and monitoring.
- We spoke with a member of the local ambulance service who was acting as a hospital ambulance liaison officer (HALO) within the department to help with the flow in the department. We spoke with six other ambulance crews who described the department as well organised and staff within the department were friendly and professional.
- The Operations Control Room (OCR) was located within the department. The OCR had an overview of the bed status trust wide and held regular meetings with other departments three times a day. We observed senior nursing and medical staff from ED liaising with staff in the OCR to maintain flow. We spoke with staff that worked in the OCR and they described how they worked with the ED team to ensure that the doors were always open for emergencies.
- The department had also formed a trauma committee to support its status in the EETN which held monthly

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meetings attended by members of the surgical, imaging and transfusion departments and was chaired by the lead ED consultant representing the trust in the trauma network.

## Seven-day services

- The adults and children's ED was operational 24 hours a day, seven days a week.
- The department had access to physiotherapy and occupational therapists seven days a week to support those patients attending that could be discharged.
- The department had 24 hour, seven day a week access to a dedicated x-ray facility within the ED which was supported by colleagues from the radiology department. We saw evidence that this had been risk assessed and met with Ionising Radiation (Medical Exposure) Regulations (IRMER) European guidelines.
- The ED had access to an emergency and trauma theatre as per national guidance 24 hours a day, seven days a week.
- A navigator nurse employed by the community was available to support the ED seven days a week. The navigator nurse worked together with a therapist and social worker to identify patients that could be supported in the community and avoid admissions.
- Pharmacy support was available to the department seven days a week. Monday to Friday between 8am and 530pm weekends and bank holidays between 10am and 3pm. There was an on-call pharmacist available outside of these hours.

## Access to information

- We saw folders in both children's and adults ED containing information relating to pathways of care and policies and procedures and staff told us that they could also access guidance and information via the intranet. Agency and bank staff received training regarding accessing information as part of their induction in regards to the electronic systems used in the ED.
- Paper records for patients presenting to the ED were readily available and staff told us they were able to access the electronic patient record form to request and receive diagnostics.
- Staff confirmed that they had access to relevant information about patients, including from GPs when required.

- The department had developed a sharing system with local community services to allow them electronic access to GP and community services' records for patients with complex needs to help co-ordinate care.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke to nursing and medical staff that were able to describe the relevant consent and decision making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in place to protect patients. Patients' consent was obtained as per trust procedures.
- We saw that the trust's MCA policy was kept in the department and was up to date. Staff received training in regards to MCA and DoLS as part of their adult safeguarding training. Nursing staff that we spoke to were able to discuss the use of proportionate restraint when it was in the best interest of the patient and in line with the trust's policy on Sedation and Restraint. We were told that security guards were available when requested but did not have powers of restraint.
- All nursing staff we spoke to in children's ED were able to demonstrate how Gillick competence and Fraser guidelines relate to the consent process in their practice.
- The trust's policy was that staff at Band 6 and above (including medical staff) should receive specific training related to MCA and DoLS in line with the trust wide target of 80% and 77% of all relevant staff in the ED had received this training.

## Are urgent and emergency services caring?

Good



We rated the service as good overall for caring because:

- We found staff to be compassionate towards patients and their families;
- Patients told us that staff had treated them with kindness, dignity and respect;
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way;

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- We observed staff using different styles of communication to involve patients in their care and treatment;
- There were good support systems in place to help people cope emotionally with their treatment or condition.

## Compassionate care

- Patients and those close to them were generally treated with respect, including when receiving personal care.
- Most people who used the service felt supported and well-cared. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them.
- We observed staff taking the time to interact with patients and their relatives or those accompanying patients.
- We observed medical and nursing staff comforting patients appropriately that were distressed.
- We spoke to patients who stated that the staff had been friendly, professional and helpful.
- Staff generally respected people's individual preferences, habits, culture, faith and background.
- Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- Confidentiality was generally respected at all times when delivering care, in staff discussions with people and those close to them.
- In the CQC's 2014 A&E survey, the trust scored the same as other trusts in all 24 questions relating to caring with an overall score of 7.5 out of 10.
- In November 2015, the response rate for the A&E Friends and Family Test was 4% of which 95% of patients stated they would recommend the service to family and friends. In October 2015, the response rate was 2% of which 90% of patients stated they would recommend the service to family and friends. There was an action plan in place to try and increase the response rate.
- In the CQC's 2014 A&E survey, the service scored 6.6 out of 10 for the question: "Were you given enough privacy when discussing your condition with the receptionist?" and scored 8.8 out of 10 for the question: "Were you given enough privacy when being examined or treated". Both scores were about same as for other trusts.

- We spoke to medical, nursing, domestic and administrative staff who always referred to people attending ED as 'our patients'.
- We saw nursing and medical staff ensuring that curtains were kept closed when patients were being treated.

## Understanding and involvement of patients and those close to them

- Staff involved patients as partners in their own care and in making decisions, with support where needed.
- Most patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that people could understand and was appropriate and respectful.
- Verbal and written information that enabled people who use the service to understand their care was available to meet people's communication needs.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition and treatment options.
- We spoke with a patient's relative in the waiting area who said that the nurse had come out and explained where the patient was and how much longer they may have to wait, at the patient's request.
- We spoke to junior staff under supervision in children's ED who were able to give specific examples of how they involved patient's parents in the pain management process.
- We observed staff modifying their language, tone and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.

## Emotional support

- A chaplaincy service was available for all faiths to offer support.
- Staff described instances where they were given time to provide support to families after bereavement and we saw information relating to bereavement services.
- Staff would direct patients and carers to services that provide counselling and support for people living with different conditions when required.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.

# Urgent and emergency services

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

**Outstanding**



Overall, we rated the service as outstanding for responsiveness because:

- Between December 2014 and November 2015, the department exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The trust had been meeting this target annually since February 2012 and was one of the top five performing trusts in the country.
- Staff showed a good awareness and knowledge of equality and diversity and we saw evidence that this formed a part of service planning with external providers and local authorities. Services were planned and delivered in a co-ordinated way that met the needs of the local population.
- We saw good planning and service delivery designed to support people with complex needs.
- There was clear evidence of learning shared and improvements made as a result of listening to complaints and concerns.
- The department was a part of the East of England Trauma network (EETN) providing specialist care for patients with serious traumatic injuries. Between December 2014 and November 2015, there had been no patients waiting in ED for over 12 hours, after a decision had been made to admit them to hospital for care.
- The department had pathways of admission to ambulatory care for patients with specific diagnosis' who could be treated as outpatients and reduce the need for admissions.

## **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 clinic which was adjacent to the ED. This was in line with RCEM guidance on how to achieve safe, sustainable care in emergency departments.

- The department had recently undergone changes to the design and layout to improve capacity and patient flow. Staff told us that these changes were good, but still felt that the size of the department should be increased.
- The department had increased their level of consultancy staffing to provide greater cover over seven days a week.
- The department had recently developed networks with external providers to deliver increased mental health provisions for the local population. We saw evidence that some of these services provided help and support for people with eating disorders and substance abuse. There were plans to monitor how this had impacted on the reduction of avoidable admissions and the department had a CQUIN in place related to this with defined targets in place for each quarter.
- The Clinical Navigation Team (CNT) worked within the ED and was staffed by community nurses working with the hospital physiotherapy and occupational therapy teams to identify patients presenting to ED who might need community support. We saw evidence that the department had worked with external providers to plan and deliver this service since April 2015. Performance over this period had been monitored and improvements made which resulted in a reduction of avoidable admissions through co-ordinated care.
- The service received patients that had sustained major trauma and were transported by air ambulance. Staff told us that the landing area for the helicopter was in a school field which was 2.5 miles away and that the new design would create a helipad which would mean that patients would arrive for treatment sooner.

## **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. Between December 2014 and November 2015, the trust exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The trust had been meeting this target annually since February 2012 and was one of the top five performing trusts nationally.
- The department was supported by the operations control room (OCR) team to manage patient flow. The

# Urgent and emergency services

systems used by the OCR team allowed them to have an overview of bed availability in the hospital and also the flow of patients coming into the ED. Staff explained that with this information they were able to plan on an hourly basis and minimise the amount of patients waiting to be admitted. Staff told us that there were three regular meetings held daily in the OCR where matrons and senior staff discussed bed availability and staffing levels.

- The ED had an electronic screen in the waiting area that displayed the average waiting time for patients to be seen. We saw ED reception staff checking that this time was accurate and also patients were advised verbally how long the average wait was.
- The proportion of patients leaving before being seen was lower than the England average. Between October 2014 and September 2015, 2% of all patients left before being seen compared to the England average of 3%.
- In the CQC's 2014 A&E survey, the service scored 6.6 out of 10 for the question: "Overall, how long did your visit to the A&E Department last?". This was about the same as other trusts.
- Between December 2014 and November 2015, the percentage of patients waiting four to 12 hours after a senior clinician had made the decision for a patient to be admitted was consistently below the England average. Between June 2015 and November 2015, the percentage for this trust was less than 1% compared to the England average of 8%. Senior staff told us that they regarded patients waiting for 12 hours in ED after a decision to admit had been made as 'Never Events' as there were set procedures in place to avoid this happening. There had been no patients recorded as waiting for over 12 hours between December 2014 and November 2015.
- Between October 2014 and September 2015, the average time to treatment was 59 minutes, which met the standard of 60 minutes and was worse than the England average of 53 minutes.
- The department had a clear escalation policy in place to address capacity issues within the hospital and to maintain the access and flow in the ED. The policy set out clear 'triggers' or factors that could impact on patient flow through ED, for example, a specified number of patients arriving within a defined period of time. There were clear steps to follow for each trigger and once these steps were followed instructions on how to proceed.
- The matron and senior nursing staff had an overview of the number of the patients in the department and worked with the OCR who had an overview of the bed capacity of the whole hospital. If it was identified that the bed availability in the hospital may not meet the demand for patients who arrived in ED and required admission the policy identified specific areas within the hospital. This included utilising the children's ED as an extension of EAU for a temporary period when specific triggers had been met. The policy set out how this should be carried out to ensure patient safety for children and adults. This process was monitored and reviewed on a regular basis.
- Between November 2014 and October 2015, there were 174 black breaches at this trust where handovers from ambulance arrival to the patient being offloaded to the Emergency Department took longer than 60 minutes. However, 48% of these breaches took place in two months alone (with 53 breaches in December 2014 and 32 in March 2015). This equated to an average of 15 black breaches per month. The ED senior staff ensured there was clinical oversight of those patients awaiting handover.
- The trust told us that December 2014 was an exceptionally busy month for ambulance attendances at the hospital. During December 2014, there was 16% increase in ambulance activity with the department receiving an average of 93 ambulances a day that was, at the time, unprecedented. The number of black breaches represented just 0.7% of the total ED attendances and 0.4% of the whole site attendances during the month. March 2015 was also an exceptionally busy month for the service with a 7% increase in ED attendance and a 6% increase in ambulance activity. This increase in demand led to some delays in the ED. This represented just 0.5% of the total ED attendances and 0.3% of the whole site attendances during the month. An additional five cubicles were opened in the department in December 2014 to help manage this increase in demand.
- The department had admissions pathways to the ambulatory care centre from Monday to Friday 9am to 9pm. Patients who presented to ED were assessed by a clinician and if their symptoms suggested that they may have specific conditions including cellulitis, deep vein

# Urgent and emergency services

thrombosis (DVT) and pulmonary embolisms (PE), they would be directed to ambulatory care centre. Outside of these hours patients who met the criteria for ambulatory care were referred to the EAU.

## Meeting people's individual needs

- The department had a clear pathway in place for people with learning disabilities who attend the ED to ensure they are safe and included in their care and treatment. This included having access to a quiet area if required. Staff told us a learning disability liaison nurse was available to the department Monday to Friday 9am to 5pm to support patients and to help staff with training in communicating with people with learning disabilities.
- We saw that the department had a 'distraction box' for patients living with dementia and the department had 'This is me' booklets on display. Staff were able to explain the relevance of these booklets and how they used them to help care for people with living dementia.
- The department had access to language translation services and face-to-face interpreters. Nursing and reception staff told us that they served a diverse population and they felt this was reflected in their workforce and they had called upon colleagues within the department to assist with language barriers and getting the right interpreter services.
- There were a number of information bulletins on display in different areas of the ED which were all printed in English. Staff said that they were able to access the documents online and print in different languages if required. The matron told us the provision of leaflets in different languages had been discussed in meetings and that the plan was to identify the 10 most frequently used languages and have leaflets and signs in these languages throughout the department.
- Staff in the ED worked with the integrated discharge team to manage patients with complex needs who were identified as being better cared for with support in the community.
- A private room was available for relatives and those accompanying acutely unwell patients to discuss sensitive situations.
- The department had access to the psychiatric liaison team 24 hours a day, seven days a week. Staff told us that a psychiatric liaison nurse was available to the department Monday to Friday 9am to 5pm and there was a crisis team available at all times.

- Children's ED had a specific pathway for access to Children and Adolescent Mental Health Services (CAMHS). Staff told us this had been an issue in the past and that there had been delays in arranging psychiatric assessments and admissions. Work was on-going at the time of our inspection with new external providers. This had been listed on the department risk register since November 2015 with an action plan in place aimed to improve services by increasing access to local services, and this was due to be reviewed at the end of February 2016.
- The children's waiting area had a number of 'distraction' items such as colourful pictures and educational toys.
- There were adequate facilities in waiting areas, with a water machine and healthy options in a vending machine.
- There was a small kitchenette available for relatives and staff that contained a toaster, microwave, small domestic refrigerator and tea and coffee making facilities.

## 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.
- Between October 2014 and September 2015, the ED received 96 complaints. We saw evidence of learning and improvements made as a result of complaints. For example, a parent expressed concerns regarding the level of compassion and empathy displayed by a member of the medical staff; empathy and communication were covered in medical staff inductions and staff were reminded of the importance of interacting with patients through briefings. We also saw evidence of staff being reminded about the importance of full neurovascular examination in limb injuries after a patient's fracture healed incorrectly. In that instance the protocol had been followed but there was no evidence in the notes that the possibility of nerve damage had been robustly investigated.
- The Matron's monthly dashboard had a section which showed how many complaints and compliments the department had received and what the themes were. This learning was shared through departmental and trust wide newsletters, the departmental quality safety board and through daily safety briefings.

# Urgent and emergency services

- We also saw evidence of people using the service being offered apologies and instances where local meetings were held to discuss patients' concerns or complaint.
- There were no complaints referred to the Parliamentary and Health Service Ombudsman and complaints were dealt with in a timely manner in accordance with trust policies.

## Are urgent and emergency services well-led?

Outstanding 

We rated the service overall as outstanding for well-led because:

- There was an innovative, clear vision and strategy for the department which looked to transform patient access to Urgent and Emergency Care across the whole health economy;
- The ED had been recognised nationally with senior NHS and Government leaders spending time in the service analysing how the department was run and the way it interfaced with the rest of the hospital to understand how the department had been able to consistently deliver against the four hour standard whilst at the same time maintaining its quality indicators.
- There was a robust governance system in place to support the delivery of the strategy and provide continuing assurances up to board level with the clear focus on patient safety;
- Leaders at all levels prioritised safety and collaborative working to improve patient care;
- All staff we spoke to spoke very highly of the leaders of the department;
- Leaders had an inspiring shared purpose, strove to deliver and to motivate staff to succeed;
- Leaders were visible and approachable and encouraged a culture of transparency and openness;
- There were very high levels of staff satisfaction within the service and staff we spoke to were proud of being a part of the department and felt very well supported;
- Staff told us that they regularly saw senior staff up to executive level in the department assisting with operational functions and talking with staff;

- Staff at all levels were encouraged and supported to explore innovative ways of working; leaders drove continuous improvement and there was a clear, proactive approach to seeking out and embedding new and more sustainable models of care.
- Human factors training encouraged people to understand why mistakes happen and minimise the risk of them occurring.

## Vision and strategy for this service

- The strategic plan for this service set out defined realistic objectives for the future growth and sustainability of the department. This included; continued performance against clinical indicators despite increasing levels of activity, progressing plans to deliver Hyper-Acute Stroke Services, maintenance of trauma unit status and becoming an acute trust member of the new East of England Urgent and Emergency care network.
- Since 2012, the department had undergone a number of changes in line with national guidelines and recommendations including working towards a 24/7 consultant-led department.
- A part of the trust's strategy was to become a major emergency centre with the ED as a major emergency department in line with recommendations made in the Keogh report 'Transforming Urgent and Emergency Services in England' published in November 2013.
- Working with key partners in Luton and Bedfordshire, the service was playing an important role in the development of an Integrated Urgent Care service in the region (including the transformation of the 111 service, out of hours GP service and the development of a clinical hub). This was planned for April 2017, and this whole service transformation of patient access to Urgent and Emergency services would represent one of the first health economies in the county to develop this new approach.
- Staff that we spoke to were aware of the plans for growth and were positive about the changes improving patient care and felt that they were a part of it.
- Staff were aware of the trust's values and felt that patient safety and quality care should be at the heart of everything they do; we heard this from staff at all levels.
- Progress against the strategy was monitored and reviewed with updates disseminated via departmental meetings and fed through to executive level through multi-disciplinary team meetings.

# Urgent and emergency services

## Governance, risk management and quality measurement

- There was a robust governance system in place and monthly meetings were held and these were well attended by staff at all levels.
- There was a holistic understanding of performance which integrated the needs of other areas in the trust and the needs of the community whilst focusing on patient safety and quality improvements within the department.
- The focus of all staff in the ED was to ensure all patients were seen and treated in a timely manner to ensure safe care. This was reflected in the service's continuing excellent performance in meeting the 4 hour standard for patient assessment within the ED.
- The department had 11 risks on their risk register which related to staffing levels for nursing and medical staff, children's ED being used as an escalation area, IT issues and access to mental health services. These risks were also on the trust wide register and it was clear who had responsibility for each risk and action plans were in place and being monitored. Mandatory training levels were not on the ED risk register; senior staff told us this was because that issue was on the trust wide risk register. Senior nursing and medical staff in ED responsible for areas of training had plans in place to address the issue.
- The risks present on the register reflected the views of the staff we spoke to at all levels.
- The department had a clear plan for internal audits in relation to reducing health care associated illnesses (HCAs) and continuously improving performance in key areas such as sepsis treatment and managing major trauma patients.
- The matron's dashboard was used to measure and monitor quality and safety performance on a monthly basis and was used as a basis for clinical governance meetings with the focus on continuous improvement of the service.
- The service contributed to national audits to benchmark performance to continuously develop the service. When the trust recognised that the department's submission for the RCEM audits for 2013/14 and 2014/15 had not been reflected in the national reports, due to an administrative error, benchmarking of performance based on the outcomes of the RCEM audits was carried out to understand the national position and

to compare performance. Action plans to improve performance based on these audits had been put in place to drive improvements. The department had completed the data submission to the 2015/16 RCEM audits and were awaiting the outcome of this national audit.

## Leadership of service

- The department was led by the matron, general manager and a clinical lead who held regular meetings with staff at all levels within the ED, other departments and external providers. There was a clear management structure with a well-established and consistent leadership team.
- Visionary leadership from the Board to all areas of ED resulted in the ownership of the emergency pathway throughout the hospital. The leadership team in ED over the past five years had transformed the service from one of the worst performing ED's in the country, to one of best performing nationally. This significant improvement in performance, despite a continuing rise in year on year attendances, had been recognised at a national level by senior NHS and government leaders.
- The ED had been recognised nationally with senior NHS and Government leaders spending time in the service analysing how the department was run and the way it interfaced with the rest of the hospital to understand how the department had been able to consistently deliver against the four hour standard whilst at the same time maintaining its quality indicators. The department's leaders had undertaken presentations at national conferences and had hosted visits from other NHS trusts to share learning at a national level.
- The leadership and the whole department's ethos was that the Department of Health standard for measuring performance (the four hour performance measure) was not an arbitrary timescale, and was based upon evidence of delivering quality care within a safe and realistic time. Fundamental to this was the fact that patients who waited for a long time had worse clinical outcomes and a poor patient experience. The department had been instrumental in conveying this message to the rest of the trust and the wider health economy. This had enabled effective patient flow through and out of the hospital, in order that the ED could see the new patients quickly, safely and effectively.

# Urgent and emergency services

- The leadership team demonstrated a clear and innovative approach to assessing and managing patient flow and safety within the ED with the development of the “forward view” approach harnessing the expertise of senior consultants to predict all likely care requirements for all patients as they progressed through their clinical pathway. There was a clear commitment and focus by all senior leaders to predict and respond to patients demand and flow issues within the ED and this was clearly supported by all other departments in the hospital.
- We saw clear evidence of leaders in this service working closely with their teams to develop their service and encouraging more junior staff to contribute to improvements.
- At times when the service experienced high volumes of attendances, we were told by staff that leaders were visible and worked as part of the team to maintain patient flow. We observed this practice throughout our inspection.
- All staff we spoke to said that their leaders were approachable and visible and they felt confident that they could voice concerns openly and they would be listened to.
- The department had an established and experienced leadership team who were aware of the present and future social and economic challenges related to delivering safe quality patient care whilst delivering their strategic plan.
- We spoke with the leaders of the department who described a supportive working environment which was corroborated when we spoke to more junior members of staff.
- During our interview with the leaders of this service they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service.
- We asked staff at all levels about the morale of the department and they all said that morale was generally good and they worked as a team. There was a consensus that morale tended to be lower during winter pressure months due to increased activity within the department.
- We saw evidence of how the service is working towards meeting the requirements related to the Duty of Candour and examples of where this had been carried out. Staff we spoke to felt that identifying when something went wrong could help them to improve patient safety and that when this did occur individuals involved were well supported through reflection, supervision and training and learning was shared.
- The department’s dedicated newsletter highlighted improvements and changes made through learning from complaints and incidents and also provided information to support the health and wellbeing of staff.
- Staff at all levels also told us that although achieving targets was important they were not afraid of breaching a target if it meant that the patient was safe and received the correct care including admission to an appropriate speciality.

## Public engagement

- Patients and those close to them were given the opportunity to provide feedback through comment cards in the department.
- The patient experience call centre based at the trust also called patients 48 hours after discharge and conducted the FFT and other questions relating to their experience. Between April 2015 and September 2015, the results of the call centre survey showed that 69% of the 270 patients contacted were likely to recommend this service to friends and family, 70% of patients felt that they had been as involved with their treatment as they wanted to be, 6% of people felt that communication with medical staff had been poor and 3% felt that communications with nursing staff had been poor. It was identified that the response for FFT was low and the department had a plan to increase this through engaging volunteers to assist with collecting the information, exploring ways of using technology such as mobile devices to enable patients, friends and family to complete the form in the waiting area and encouraging staff to hand these out when appropriate.

## Culture within the service

- The clinical leaders had transformed the culture of the service to embed patient safety within operational and clinical practice with the clear focus on ensuring the four hour standard for patients’ clinical assessments was continually met.
- We found the culture of the department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders.

# Urgent and emergency services

- Staff in the children's ED told us that they had an 'expert parents' group who helped staff understand the needs of children with complex needs by sharing their experiences.

## Staff engagement

- Staff were encouraged to share experiences and comment on changes and ideas for improvement through the departmental newsletter
- We spoke to staff in the children's ED who had been involved in developing the escalation policy and they told us that their input had improved the process and made it safe; we saw evidence of the changes made.
- The trust had run events in 2015 for staff from all departments to attend which some staff from the ED had been able to attend and share their views on a range of issues including the future growth of the trust.
- Staff told us it was difficult to have full team meetings as it meant staff attending on their rostered days and having adequate cover.
- Staff said that they felt their opinion mattered and a member of staff described how they had been included and helped to improve the safety of the service when they voiced concerns regarding the escalation policy and it was acted upon.
- We saw evidence of staff receiving recognition for their contribution to the service through internal annual awards ceremonies.
- Results of the 2014 NHS staff survey for the trust (the 2015 results were not available at the time of inspection) showed that the five bottom ranking scores related to bullying, harassment, violence and aggression and working extra hours. Staff that we spoke to did not express any concerns in relation to bullying, harassment or violence and aggression.

## Innovation, improvement and sustainability

- We asked staff at different levels how they felt that they were able to meet the four hours to discharge target consistently. All staff we spoke to felt that it was a combined effort and the emphasis on patient flow and the function of the operations centre room (OCR) allowed them to concentrate on patient care.

- The department had strong links in operational delivery networks in the East of England; this included East of England trauma network and East of England Urgent and Emergency care network.
- Streaming at the ED reception and working with the external providers at the Urgent GP Centre had an impact on reducing avoidable admissions and with continuous monitoring and feedback at all levels involved, new pathways had been developed and continuous learning implemented.
- The functions of the OCR included an early warning system which allowed staff to identify pressures in the system and co-ordinate resources to meet variances in demand.
- The department had recently started concentrating on human factors training which is regarded as being beneficial in the NHS. The principles and practices of human factors focus on optimising human performance through better understanding of individual's behaviour, their interactions with each other and with their environment. Staff told us that this approach emphasised the benefits of being open about errors in order to improve patient safety.
- The introduction of the 'Quality Board' in communal staff areas had been as a result of senior nursing staff visiting another trust and learning from them. The matron and senior nursing staff told us that this was another way they hoped to continue sharing best practice and make improvements.
- Senior staff told us the decontamination unit was developed in response to the Ebola outbreak in 2014 and that they had carried out extensive training and research in preparedness.
- Leaders of the department spoke about applying to become an 'NHS vanguard' site in line with the national programme for improvement and better integration of services which started in 2015. NHS Vanguard sites were designed to provide models of care that are innovative and focus on quality patient care and cost efficiency.
- The ED had developed appropriate safety measures and protocols regarding patients presenting with potential haemorrhagic fever with a clear pathway linked to the hospital's infection control ward: this had been recognised at a national and international level.

# Medical care (including older people's care)

Safe	<b>Requires improvement</b>	
Effective	<b>Requires improvement</b>	
Caring	<b>Good</b>	
Responsive	<b>Good</b>	
Well-led	<b>Good</b>	
<b>Overall</b>	<b>Requires improvement</b>	

## Information about the service

The Luton and Dunstable University Hospital NHS Foundation Trust (L&D) provides cancer and palliative care services to patients and their families. The L&D consultants treat the following specialties: breast, lung, colorectal, oesophageal and gastric, pancreatic, gynaecology, urology, haematology skin, head and neck and thyroid. They offer onward referral to other specialist hospitals, if required.

The L&D provides cardiology, gastroenterology, respiratory medicine and stroke services within the medical services. The trust also provides services to elderly patients and those living with dementia. There are two medical short stay units, a cardiac centre and two emergency assessment units (EAU).

There were 11 medical wards within the trust, comprising of 298 beds. Between January 2015 and December 2015, there were 31,602 inpatient admissions of which 965 were elective, 8,714 were day cases and 21,923 were emergency admissions.

We inspected EAU 1, EAU 2, the stroke ward, respiratory, elderly care and dementia wards, general and speciality medicine wards, coronary care unit (CCU) and the cardiac centre. We carried out an announced inspection visit on 19 to 21 January 2016 and an unannounced visit on 27 January 2016.

We spoke with 48 patients, five family members, and 43 members of staff including clinical leads, service managers, matrons, ward staff, therapists, junior doctors, consultants, and other non-clinical staff. We also looked at the care plans and associated records of 48 patients.

We observed interactions between patients and staff, considered the environment, and attended handovers and ward board meetings. We also reviewed other documentation from stakeholders and performance information from the trust.

# Medical care (including older people's care)

## Summary of findings

Overall, we rated medical care at this hospital to be requiring improvement.

Safety within the medical service was rated as requiring improvement. Not all staff adhered to infection control preventions at all times. Infection control training was below the trust target for medical staff. We found inconsistencies in the recording of medicine administration on some wards. We found no process to enable patients to self-administer their medicines, which the service stated was to be addressed. Not all medical staff had had the required level of safeguarding adults and children's training. Many nursing staff had not received their conflict resolution training.

Not all venous thromboembolism (VTE) assessments were completed in accordance with trust policy. The service was aware of this concern and was taking actions to improve completion of these assessments and carrying out regular audits. Whilst the service was improving the number of patients that received appropriate antibiotics within one hour for the management of suspected sepsis, not all patients were having appropriate treatment within the specified time. Consultant reviews were inconsistent. The mortality review report for December 2015 recommended a standardisation of consultant ward rounds within the medicine service. On most wards consultants visited their patients every two or three days.

Nursing and medical staff had regular mandatory training with the exception of conflict resolution. Although there was a high use of agency, bank and locums in medical and nursing specialities, we found no issues or concern within the staffing levels on the wards visited. We saw good practice regarding the safeguarding of vulnerable adults. Staff took a proactive approach to the early identification of safeguarding concerns. Staff understood their responsibilities to raise concerns and report incidents and near misses. We also found that equipment used for patient care was in service date and had been maintained or electrical safety tested. There were systems and processes in place to assess and manage the risks to patients.

We judged that the effectiveness of this service as requiring improvement because patients were not always receiving effective care and treatment. The Hospital Standardised Mortality ratio (HSMR) was rising above the expected rate; the service was taking a series of actions to understand and address this issue. Outcomes for patients were variable as compared to similar services and where outcomes were below expectations, the service was taking a series of actions to address this.

There was participation in relevant local and national audits such as national diabetes and the heart failure audit but outcomes were mixed and whilst plans were in place to improve performance, progress was variable. The trust SSNAP data regarding stroke indicated that there were issues with the stroke pathway and the service was taking a series of actions to improve performance indicators. Plans were in place to provide a seven day service, but not all patients were being reviewed by consultants on a daily basis.

The trust had effective evidence based care and treatment policies based on national guidance. Patients' pain was assessed and pain relief provided appropriately. Patients' nutrition and hydration status were assessed and recorded on all the medical wards. We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment. Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience. Consent to care and treatment was obtained in line with legislation and guidance and, deprivation of liberty was applied appropriately.

We found medicine services to be caring. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients received good care, compassion, dignity and respect. We observed patients received good emotional support.

We rated the service's responsiveness as good. Access and flow in and out of the medicine services posed problems with delayed discharges identified as an area that required improvement. The referral to treatment time was being achieved and the number of patients

# Medical care (including older people's care)

being moved between wards was low. Staff understood the procedures regarding complaints. However, they said that any complaint received would firstly be resolved locally. This meant that the outcomes, themes or lessons learnt were not cascaded to staff. Patients' relatives said they were involved and kept informed. There was good awareness of the needs of people living with dementia, learning disability or mental health needs.

We rated the medicine service as good for being well-led. There was a clear vision and strategy for the future of the service. Senior staff and clinicians attended governance meetings. Staff said the recent reconfiguration of the service had improved morale. The staff survey reflected this. Whilst the service had generally recognised the risks to patient safety and progress the quality of care and treatment, actions were not always clearly defined and therefore progress was variable. Learning from mixed performance at national audits was not always effectively used to drive forward improvements in a timely manner.

## Are medical care services safe?

Requires improvement 

Overall, we rated the safety of medical services as requiring improvement because:

- Not all venous thromboembolism (VTE) assessments were completed in accordance with trust policy. The service was aware of this concern and were taking actions to improve completion of these assessments and carrying out regular audits.
- Whilst the service was improving the number of patients that received appropriate antibiotics within one hour for the management of suspected sepsis, not all patients were having appropriate treatment within the specified time.
- Consultant reviews were inconsistent. The mortality review report for December 2015 recommended a standardisation of consultant ward rounds within the medicine service. On most wards consultants visited their patients every two or three days.
- Not all medical staff had had the required level of safeguarding adults and children's training.
- Not all staff adhered to infection control preventions at all times. Infection control training was below the trust target for medical staff.
- We found inconsistencies in the recording of medicine administration on some wards which was brought to the attention of senior staff. There were delays in dispensing discharged medicines.
- We found no process to enable patients to self-administer their medicines, which the service stated was to be addressed.
- Not all medical staff had had the required level of safeguarding adults and children's training.
- Many nursing staff had not received their conflict resolution training. This meant there was a risk of staff not being able to manage some patients who displayed challenging behaviour.

However, we also found that:

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- All equipment viewed was in service date, and had been maintained or electrically safety tested and was fit for use.

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- The service had procedures in place regarding the prevention of infectious diseases and recent audits showed improved performance to meet the service's targets.
- In endoscopy, decontamination processes were consistent across all areas.
- We saw good practice including the safeguarding of vulnerable adults which was given sufficient priority and staff took a proactive approach to the early identification of safeguarding concerns.
- We found that generally nursing and medical staff had regular mandatory training.
- Records were generally well maintained and kept securely.
- Nurse staffing levels met patients' needs at the time of the inspection. Staffing shortages were acted upon appropriately with the use of temporary staff and an effective induction processes were in place.
- Medical staffing was appropriate and there were effective arrangements for our of hours cover.
- The trust had recognised the risks associated with the management of patients spread over a number of wards and had introduced a model to improve the management of medical and the department of medical elderly (DME) outliers.

## Incidents

- Staff described how they would be open and transparent regarding any incidents. Staff said they understood their responsibilities to raise concerns and report incidents and near misses. They said they were fully supported when they did so.
- Between December 2014 and November 2015, medicine services reported 18 serious incidents through the National Reporting and Learning System (NRLS). The most frequently reported incident types were slip, trips and falls of which there were seven. None of the serious incidents reported were classified as a never event. A never event is defined as: "A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers."
- All serious incidents were overseen and reviewed by a trust panel. Senior staff said the panel identified any learning and fed back to the teams. Staff reported getting feedback from incidents via email, staff meetings and during handovers. Serious incidents folders were available in all the clinical areas. Staff felt this was a useful learning tool which informed staff of incidents that had occurred both locally and trust wide. We saw evidence of staff signatures which indicated they had read the information contained in the folder.
- The trends and themes analysis for falls revealed an increasing number of falls at night and also around patients' toileting needs. Senior staff said that the falls clinical nurse specialist had worked with ward staff on the use of the falls sensor equipment.
- There had been an increase in the incidents of pressure ulcers in July 2015 (15 patients) with a consistent decrease in the following months. The Quality and Performance report for September 2015 identified that all reported pressure ulcers had been subject to a root cause analysis. We saw copies of these during our inspection. This resulted in specific attention being given to reducing skin damage on patients' heels. This was addressed through the use of hand held mirrors and the use of alternative pressure relieving devices. The trust held a "pressure ulcer awareness" day with support from the tissue viability nurses in November 2015. The day focussed on wound categorisation, heel damage and dressings use. The results showed that 100% of patients had been risk assessed for pressure sores within general medicine and 96% within elderly medicine. The results also showed there had been no hospital acquired pressure sores.
- Staff told us how incidents were recorded and reported via the trust's computerised incident recording system. Most staff told us that they had received feedback about incidents, but some staff said they did not know what happened to the reported information.
- Patient safety information was displayed on ward performance boards. Senior staff told us that general feedback on patient safety information was discussed at monthly ward/staff meetings. This was identified in the minutes seen.
- The junior doctors told us they were encouraged to report incidents and received training during their induction. They said they had received feedback from investigation findings.
- We saw the result of a root cause analysis (RCA) following a cardiac arrest on ward 5. The analysis identified that all protocols had been followed which included the completion of documentation and the

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correct life support procedures. Staff described the results of the RCA and the procedures they would take if a patient went into a cardiac arrest. This meant that lessons were cascaded to staff regarding incidents.

- Senior staff attended mortality and morbidity meetings. The purpose of the mortality meetings was to routinely monitor death rates within the hospital for certain diseases or procedures to identify where numbers of adverse outcomes are unusually high (outliers) and to follow these up appropriately. They were aware of the review by the mortality board and had participated in monthly meetings to review and discuss individual cases to determine if there could be any shared learning.

## Duty of Candour

- 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 understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- Staff described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm.
- The matrons said they reviewed all incidents and followed the duty of candour process for all incidents identified as moderate or above. We saw all incidents fed into the trust's governance structure and were reviewed by the trust panel.

## Safety thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harms which included new pressure ulcers, catheter urinary tract infections and falls.

- The medical division participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas.
- Data for the medicine division dated December 2014 to December 2015 showed a total of 37 pressure ulcers, 12 falls with harm and 13 catheter associated urinary tract infections. We saw these had been reviewed during staff meetings and recorded on the quality dashboard.
- All the areas we inspected had a safety dashboard on display, this meant patients and the public could see how the ward was performing in relation to patient safety. Areas covered included; infection control measures, results of friends and family tests, the number of complaints and the levels of staff on shift.
- The trust had guidance to reduce the number of pressure ulcers acquired within the hospital. The trust's tissue viability nursing team had adopted the "Stop the Pressure" campaign. The simple steps to prevent pressure ulcers (SSKIN) model provided guidance on how to prevent and treat pressure ulcers. Staff said they were aware and used the SSKIN model. This was evidenced in the records reviewed.
- Safety thermometer data was incorporated into the divisional quality score card dashboard. The risks monitored by the safety thermometer and other risks defined by the trust were part of the medicine service's governance meeting discussions. This showed that the data was used to monitor performance and to track risk trends. Staff were aware of these trends and actions being taken to reduce risks to patients.

## Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean, and cleaning schedules were clearly displayed.
- There were key pad entry systems for storage rooms. Equipment was cleaned and marked as ready for use with "I am clean" labels.
- We saw the infection control and medical microbiology forward audit plan for 2015/16. Areas included the consistent submission of audit data regarding hand hygiene, quarterly monitoring of methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (c. difficile). We saw these were reported on the ward's quality boards.
- As at 30 November 2015, 94% of medicine nursing staff had up to date training in infection control but only 68% of medical staff. The trust's internal target for this

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training was 80%. The medical microbiology forward audit plan for 2015/16 recognised the need for medical training and had actions to complete these by the end of the first quarter of 2016.

- The cardiac centre was utilised as an escalation ward. During our visit we saw three side rooms within the unit which were used for infection control due to no other side rooms being available within the hospital. We saw there were procedures to deep clean these rooms to reduce the spread of infection.
- The cardiac centre had been identified as an infection control risk for patients undergoing an invasive investigation/procedure on the risk register dated 13 January 2015. This had been validated by the trust infection control leads and was an identified on-going risk. There were clear procedures for staff to follow regarding infection control and we found no issues or concerns during our visit. The risk register's next review of the infection control risk was 31 January 2016.
- Throughout medical services, we observed the majority of staff complied with best practice with regard to infection prevention and control policies. We observed staff washing their hands or using hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. However, we observed that not all staff on EAU1 adhered to the dress code, which was to be 'bare below the elbows'. We observed members of staff wearing many items of jewellery. This was not in line with the trust infection control policy and could increase the risk of spreading infection to others. This was brought to the attention of the matron in charge who took action to address this issue.
- Where it was suspected patients had an infection they were cared for in side rooms with signage to alert staff and visitors of the risk of infection. We saw nursing and medical staff using the appropriate equipment when entering side rooms.
- We observed housekeepers not using gloves or aprons during our visit to the wards. They told us they only used these when they visited patients who required barrier nursing. We also observed housekeeping staff not using gloves when serving food to patients. This meant there could be a risk of cross infection to patients through the inappropriate use of personal protection equipment. This was brought to the attention of the senior nurse in charge.
- There were four cases of *Clostridium difficile* (c. difficile) infections between July 2015 and September 2015 identified on wards 5, 18, 20 and 22 within the medicine division. *C. difficile* is an infective bacterium that causes diarrhoea, and can make patients very ill.
- Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections. There were no cases between July 2015 and September 2015 across the medicine service.
- We saw the quarterly surveillance report of newly MRSA and *C. difficile* toxin patients for September 2015. All health care associated infections (HCAI) were investigated by the infection control team (ICT) to identify any failures in practice or trends. The ICT reviewed all root cause analysis (RCA) reports and shared all HCAI with the individual wards and divisions. We saw the copies of three RCA's within the medicine division which had been appropriately reviewed.
- We saw the endoscope unit completed weekly water sampling and protein tests. Endoscopes underwent additional checks for the effectiveness of the cleaning process by using a protein testing kit to swab the scopes. This detects any protein residue following the decontamination process; a protein residue would indicate the decontamination process had not been successful and may therefore, present an infection control risk to other patients. All the documentation had been completed appropriately.
- We saw good decontamination procedures in place within endoscopy. Staff explained that any problems regarding the maintenance of the endoscope were sent back to the company who provided replacement loan endoscopes.
- Every endoscope was tracked electronically throughout the process which included the recording of all patients' details. This meant that the unit had systems and processes in place to protect the well-being of patients attending the unit.
- We saw the infection control audit for September 2015. This was red, amber and green (RAG) rated with red below 85%, amber 85-94% and green 95-100%. The worse performing areas were the cardiac centre at 75% and ward 4 at 78% (red). One ward scored 96% (green) whilst all the others scored between 85% and 91% (amber). Whilst there was not always a defined action plan put in place following these audits, wards were required to improve compliance with infection control procedures and this was monitored by senior staff and

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via the matron's quality and performance dashboard.

During our inspection, we saw that the safety dashboard for December 2015 identified that they had achieved a green rating in all areas.

- Hand hygiene audits were completed on a monthly basis. For the reporting period August to December 2015, the overall compliance rate for the medicine division was 96%.
- We saw the results of the 2014 (released August 2015) annual PLACE (Patient Level Assessments of the Care Environment) report. This is a snapshot self-assessment of non-clinical services which impact on the patient experience and is undertaken by patients and the public in conjunction with trust staff. The PLACE report showed the trust scored close to the national average for cleanliness.

## Environment and equipment

- The hospital received a Macmillan Quality Environment Award in February 2015 which assessed how well the hospital buildings such as the chemotherapy units provided support and care for people affected by cancer. Patients said how "impressed" they were with the improvements. One patient was reported as saying that the "new chairs are so comfortable" that they can "fall asleep whilst having their chemotherapy treatment."
- The medical services had an equipment maintenance register which identified the location of the equipment and the service date of all equipment.
- On EAU1, we found that the staff room was also being used as an equipment room. We observed staff frequently being disturbed during their break by others trying to get equipment. This meant that staff did not have an area where they could unwind and relax away from the unit. We also found the staff room on ward 5 to be cold and cramped and not conducive to staff wellbeing. We observed this was not identified on the risk register.
- On visiting ward 5, we found there was limited space for the storage of equipment. Space was cluttered and we observed staff moving equipment in order to get what they wanted.
- Staff said they had no issues in obtaining equipment from the equipment library. For example; on EAU1 they said they had no difficulty in gaining cardiac monitors for multiple patients.

- The trust had expanded and improved the capacity within the EAU as part of the overall investment in the emergency department.
- The cardiac centre was designed as an elective day case unit for angiography, percutaneous coronary intervention (PCI) and pacemaker implants. Angiography is a type of X-ray used to examine blood vessels whilst PCI is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent to open up blood vessels in the heart. The area was being used as an escalation area for acute medical admission. On visiting the ward we found there were suitable arrangements in place to ensure patients had access to bath/shower facilities and hot food.
- The cardiac centre did not have a hoist but could utilise the hoist within the adjacent ward if needed. Staff said there had been no issues with obtaining the use of a hoist when required.
- We visited ward 22a (escalation ward) and found the ward did not have any sluice facilities. However, the ward was able to utilise the facilities of the adjacent ward. We found no issues or concerns identified regarding this usage.
- There were systems to maintain and service equipment as required. We saw that fire fighting equipment and hoists had been regularly checked and serviced. Portable electrical equipment had been tested to ensure it was safe for use.
- The resuscitation equipment on the wards was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- We saw the results of the 2014 (released August 2015) annual PLACE (Patient Level Assessments of the Care Environment) report. The service did not perform so well for condition and appearance of the buildings. We saw an improvement plan had been developed which was being monitored by the PLACE committee.

## Medicines

- During our visit to the ward we observed staff carrying out medicine rounds in accordance with the Nursing and Midwifery Council (NMC) code for the administration of medicines. We saw nurses wearing a

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red tabard to indicate they were completing the medicine round and should not be disturbed. We also observed nurses explaining to patients what the medicine was and why it was being given.

- The trust used an Electronic Prescribing and Medicines Administration (EPMA) system. EPMA provided clinical staff with:
  - Immediate access to medicine information
  - Ensured the directions for medicines were legible
  - Reduced ambiguous or incomplete prescriptions.
- Members of the pharmacy team visited the wards each weekday. There was a limited service at weekends and a pharmacist available to contact out of hours. The pharmacists were not able to see all patients but they used information from the electronic system to prioritise which prescriptions to review. These included newly admitted patients so that they could take a detailed drug history and patients who had been prescribed high risk medicines so that they could check the prescriptions were correct.
- An audit undertaken in August 2015 showed there were concerns with missed doses. Among the most common reasons recorded were that the patient declined to take the medicine and the medicine was not available. We noted from the audit report that the pharmacy team was planning further work to identify how the EPMA system could be used to support the reduction in missed doses particularly due to medicine availability. Ward managers received information regarding missed through the incident reporting system which they followed up with staff.
- We looked at the prescription and medicine administration records for 17 patients on four wards (Ward 3, 11, 12 and 16). There were inconsistencies in the prescription charts completed regarding the recording and administration of medicines. Examples included:
  - Inconsistencies with the recording of blood glucose levels for three out of six medicine records on ward 3. Understanding blood glucose level ranges can be a key part of diabetes self-management.
  - Eye drops for glaucoma were recorded as unavailable on several occasions even though records showed they had been dispensed.
  - Topical creams prescribed on the EPMA did not indicate the area for administration. Staff on ward 3 said they asked the patient where the cream should be administered. This meant there was a risk of patients having topical creams being incorrectly administered.
- Alendronic acid, a medicine for osteoporosis which must be given at least 30 minutes before food or other medicines, was recorded as being given to two patients at breakfast time along with their other medicines.
- We raised these issues with senior staff at the time, and the trust took immediate action to review medicines' management on these wards. The trust had also carried out audits regarding controlled drugs and safe and secure storage of medicines in November and December 2015 on these wards and we saw that improvement action plans were in place to address identified risks.
- Pharmacy staff said there was a way to record advice for nursing staff on the system but we did not see that it had happened for these patients.
- Nursing staff said there could be a delay in prescribing and dispensing discharge medicines so patients were sometimes given the option of returning to collect their medicines at a later date. For example, on ward 11 we found a prescription belonging to a patient discharged a couple of days previously. The label said insulin was in the fridge. We asked to see the insulin, but this was not available. The charge nurse said the medicine may have been returned but there were no systems in place to monitor this. This meant that patients did not always have access to medicines when they needed them.
- There were no procedures for the self-administration of medicines within the service. For example, patients who were on insulin were not given the opportunity to self-administer. We spoke with senior nurses on the wards visited who confirmed their aim was to support patients to self-administer but this was not consistent and there were no guidance in place. Both the ward staff and pharmacy informed us the policy was in the process of being written to address the issue.
- During our visit to EAU2 we found that all oral drugs were stored in a lockable trolley. However, this was not secured to the wall and the lockable device was not in use. This was brought to the attention of the nurse in charge who arranged for the trolley to be secured.
- The quality and performance report for September 2015 identified a continuing challenge in ensuring the risk

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assessments in relation to venous thromboembolism (VTE) were completed in a timely manner. The records showed that for general medicine, 79% (26 from 33) patients had completed assessments and 80% (35 from 45) patients within elderly medicine. During our inspection we found inconsistencies within the records read with regard to VTE assessments. Of the 38 records reviewed nine were not completed correctly. The pharmacy team said they monitored the completion of the VTE but this was a challenge and this was being followed up with medical staff. The trust wide analysis regarding VTE assessments indicated a compliance rate of 64%. The trust had recognised this shortfall and had implemented continued monthly VTE reviews to ensure medical staff completed them appropriately. We saw this was an ongoing action.

- Whilst visiting the cardiac centre we observed that medicines were being administered by a clinical educator, who possessed the appropriate competencies, due to agency nurses not being able to undertake drugs rounds.
- We reviewed the storage and administration of controlled drugs on five wards. (Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation). We found them to be stored appropriately and drug records were accurately completed.
- Medicines were stored at suitable temperatures to maintain their quality. On ward 11 the refrigerator thermometer had not been re-set after each reading and the room temperature was regularly above the maximum recommended for the storage of medicines with no measures in place to ensure medicines were fit for use. This was brought to the attention of the nurse in charge who took actions to address this issue.

## Records

- During our inspection we reviewed 48 nursing and medical records. We observed the records on the wards visited were stored securely with the exception of EAU2. We saw the records were stored in a trolley at the nurse's station. This was not lockable and on the day of our visit the lid was open. This was brought to the attention of the nurse in charge who took action to address this. This meant that there was a risk of access to a patient's medical notes by an unauthorised person.
- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and

allied health professionals including physiotherapists, occupational therapists, speech and language therapists and, dietetics staff. All records were legible, accurately completed and up to date.

- Daily nursing record booklets were in use. These detailed comprehensive care plans relating to, for example, the patients identified care needs and, risk assessments for falls, pressure ulcers and nutrition.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Braden Scale.

## Safeguarding

- At the time of the inspection, 95% of medicine nursing staff had up to date training in adult safeguarding and 99% had up to date training in safeguarding children at level two. 100% of nurses needing level three safeguarding training had had this. However, only 75% of medical staff had up to date training in adult safeguarding and 68% had up to date safeguarding children's training at level two. The trust's internal target for this training was 80%. For level three safeguarding training, 63% of medical staff had had this, which was below the trust target of 100%. The education team informed us there was a continual assessment of the shortfall in training needs and there was a continuous programme for training implemented within the trust.
- Staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Staff gave examples of safeguarding raised as a result of physical and emotional abuse.
- The trust had a safeguarding lead; staff knew the name of the safeguarding lead and they told us they could approach them for advice if they needed to.
- We saw a safeguarding board displayed on the wards visited which provided information and contact details to patients, relatives and staff.

## Mandatory training

- Staff received training in mandatory topics such as infection control, information governance, manual handling, risk management, safeguarding adults (level one) and, safeguarding children (level one).

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- The records showed that 86% of mandatory training had been completed by nursing staff. This was above the target set by the trust of 80%. We saw senior staff kept good records of staff's training needs and they were sent reminders via e-mail or any outstanding training.
- Staff had knowledge of distraction techniques which they told us they would use where appropriate. However, the records showed that staff had not received their conflict resolution training. This meant that staff may not have the necessary skills to manage patients who may portray difficult behaviour.
- Senior staff told us that dementia awareness was an area that was developing within the hospital. The records showed that 63% (46% clinical and 17% non-clinical staff) had completed their dementia awareness training. The dementia speciality nurse said they were in the process of offering appropriate dementia training as part of their Commissioning for Quality and Innovation (CQUIN) framework. The aim of the CQUIN framework is to improve the quality of services provided with better outcomes to patients.
- Staff within the wards said they were given the opportunity of accessing additional specialist training. For example; staff on the respiratory ward said that they had undertaken respiratory training and senior staff said they were looking at additional tracheostomy training.
- Administer high flow oxygen
- Take Blood Cultures and consider infective source
- Give Intra Venous (IV) antimicrobials. An antimicrobial is an agent that kills micro-organisms or inhibits their growth.
- Give Intra Venous fluids
- Check haemoglobin (blood count) and measure lactate. The lactate test helps detect and measure the severity of low levels of oxygen in the body.
- Commence hourly urine output measurement.
- The recommended time for patients that presented with severe/red flag sepsis or septic shock being seen is one hour. The records showed that for October 2015 that 90% of patients and in November 2015 that 92% of patients were seen within the recommended time. The service had reviewed the data and we saw an action plan from the December 2015 audit which had identified the documentation of the time antibiotics being administered were not always being recorded and these patients were not being recognised as severely septic. The action plan specified a continued monthly review of the documentation records.
- Patients requiring non-invasive ventilation were cared for on the hospital's High Dependency Unit (HDU). The service had an appropriate policy in place outlining senior staff responsibilities and treatment plans if an HDU bed was not available.

## Assessing and responding to patient risk

- Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. NEWS were carried out as needed and concerns were escalated appropriately and deterioration was managed in according to National Institute for Health and Clinical Excellence (NICE) guidance. We saw the audit figures as of December 2015 which showed that 88% had been completed within general medicine and 91% were completed within elderly medicine. This was above the trust target of 80%.
- Patients with a diagnosis of sepsis were treated following the trust's sepsis six bundle. Sepsis is a life-threatening illness caused when the body is overcome by infection. It is often called septicaemia or blood poisoning when the body is fighting a severe infection that has spread via the bloodstream.
- The sepsis six bundle covered:
  - We saw there were structured nursing ward rounds. This enabled the nursing staff to assess and respond to patient risk in respect of; personal needs, pain, placement of items such as call bells and the positioning of patients to prevent the risk of pressure ulcers.
  - The records showed that the wards completed a range of tests for dementia screening which included blood tests, brain scans and a variety of test to assess the patient's mental abilities.
  - The wards visited had a prompt board on display. Patients had magnetic prompts such as assistance needed, special dietary requirements and the frequency of observations. This meant that staff could instantaneously see the support required for specific patients.
  - We saw an acute escalation chart on display for staff awareness in the nursing station of ward 15 (elderly care). This meant that staff could see the risk associated to a specific patient and respond accordingly.

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- We observed a patient who was confused with a high risk of falls being moved into the bay area rather than the side room on ward 19b. We saw staff had assessed the risk to the patient and responded appropriately.
- Medical staff on ward 3 said the management of patients out of hours with an acute gastro intestinal bleed could be problematic as there was no overnight on-call endoscopist. Staff confirmed patients would be transferred to a nearby hospital for any emergency treatment. This had been recognised on the risk register and the controls in place were to ensure there was joint working between colorectal and medical consultants to ensure the rota had upper gastro intestinal cover.
- We saw the risk assessments for falls. The figures reported in the mortality review meeting of December 2015 showed that 100% of patients within general medicine had been reviewed and 98% of patients within elderly care.
- We saw the stroke service used the Modified Rankin Scale (MRS) for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke or other causes of neurological disability.
- We saw examples of care being escalated promptly when a patient's condition had deteriorated. We saw evidence of a treatment escalation plan in the patient's records. Treatment escalation plans outline the level of intervention required should the patient's condition deteriorate.

## Nursing staffing

- Nurse staffing levels were appropriate during the days of the inspections; we saw the patients' needs were being met. A review of the staffing rotas did not identify any issues or concerns regarding staffing levels. Senior management informed us they had obtained the service of regular temporary staff which meant that there was continuity of care within the wards for people who used the service.
- Nursing numbers were assessed using the national Safer Nursing Care Tool and National Institute of Health and Care Excellence (NICE) 2014 guideline which identifies organisational and managerial factors that are required to support safe staffing for nursing, and makes recommendations for monitoring and taking action if

there are not enough nursing staff available to meet the nursing needs of patients on the ward. The wards used this tool to ensure they identified the minimum staffing levels required for each ward.

- The matrons participated in three times daily meetings to review patient activity with staffing levels. Any identified "hot spots" were communicated to the team in the control room for inclusion on the daily bed report. This allowed the patient flow team to assess patient movements into these areas. A hot spot is described as those patients care areas that may struggle to deliver direct patient care due to concerns such as high acuity of patients or poor skill mix. This meant the service was able to respond effectively to any nursing levels identified as a concern.
- The medicine service was facing particular challenges around nursing and doctor recruitment. The records as of August 2015 showed that the division required 1,086 staff of which they had 988. This left a short fall of 98 staff (17% vacancy rate) required across the division. The records showed a steady growth rate in staff appointments across the division each month from April 2015 which was in line with the trust's recruitment programme.
- The trust had a recruitment and retention programme. This included monthly review of nursing vacancy figures. The trust had introduced a tracker which provided up to date information on all nursing staff going through the recruitment process, ward allocations, predicted start dates and actual start dates. Access to this information was given to all matrons/ward managers.
- The Quality and Performance report for September 2015 showed the wards which had failed to meet the target of whereby 15% or more of nursing hours did not meet agreed staffing levels. These wards were 14, 15 and 16 (elderly care), ward 17 (stroke), ward 18 (infection) and ward 3 (medical short stay). We saw the actions which included that within wards 14, 15, 16, 17, and 18 a band 4 (assistant practitioner) would support the band 5 registered nurse when there is a shortfall in the staffing numbers. We saw the wards had completed the appropriate risk assessments when this had occurred. On ward 3 (medical short stay), the third trained nurse, following a risk assessment, could be replaced by a health care assistant. This meant that the service had assessed the risk associated with the required staffing levels within the wards.

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- We saw the action plan and risk assessment for ward 10 (respiratory) as there was an identified nursing vacancy factor of 15% with reliance on bank/agency staff. The staffing rotas showed there were no issues with outstanding shifts and this was confirmed by senior staff on duty.
- Nurse staffing for all contingency areas was managed through the three times a day operational staffing meetings. Each contingency area had a named matron responsible for ensuring it was safely staffed. Over periods of escalation, practice development and clinical nurse specialist teams were deployed to support these areas.
- We saw the sickness management policy which identified the trust target rate for December 2015 as 3%. We saw the medicine service had a rate of 4%. The trust had recognised this and there were processes in place within the service which included; return to work meetings and monitoring programs.
- On the day of our visit the respiratory ward had only one health care assistant (HCA) on duty for the day shift instead of the identified three HCA's. Wards used a red/amber/green (RAG) rating to reflect their actual staffing levels. Senior nurses carried out a risk assessment if the ward was short staffed to ensure that the patients' needs were being met and there was no risk to the patient. During our visit we saw the ward was successful in obtaining the services of an additional registered nurse and an agency nurse. This meant that the ward had the correct complement of staff to support the needs of the patients. Senior staff said the matron often visited the ward to assist and monitor patient's needs when nursing levels were short.
- Staff said that an extra staff member could be requested if a person needed specific one-to-one support from staff. We saw during our visit this had been implemented on ward 15 (elderly care) to support staff with patients who portrayed challenging behaviour. Staff told us they had assessed the risk and had requested additional staff to support the ward.
- There was good handover among nurses and we observed staff discussing the following:
  - Brief medical history
  - Reason for admission
  - Progress since admission
  - Any action plans
- The number of consultants was equal to the England average of 34%. Junior (foundation year 1-2) and middle grade (at least three years at senior house officer (SHO) or a higher grade within their chosen speciality) were above the England average of 6% and 22%. They trust staffing was at 9% and 29% respectively. However, the registrar grade employed doctors was at 28% which was below the England average of 39%.
- Weekend consultant cover was provided until 8pm with registrar cover until 5pm. Junior doctors covered the whole medical service out of those hours with on call support. None of the medical staff we spoke with during our inspection raised concerns regarding the level of medical cover out of hours or at weekends.
- Junior doctors told us they felt supported by their seniors and had good access to the consultant on their teams.
- We observed a ward round and saw that doctors introduced themselves to patients and provided an update to the patient and/or their relative/carer.
- Doctors conducted daily board rounds. A board round is an "at-a-glance" white board, away from the bedside. The board round provided an opportunity for the multidisciplinary team to contribute. We attended a board round and observed the following areas were addressed; discharge planning and/or any outstanding medical or nursing issues.
- On the wards consultant reviews were inconsistent with some wards reporting daily review of patients by a consultant and others reporting twice weekly reviews. The mortality review report for December 2015, reviewed the frequency of consultant review. The data showed that 22% (nine of 41 patients) had been reviewed daily, 78% (32 of 41 patients) had been reviewed between two and three days. This meant that all patients had been seen within three days. Within the elderly medicine, 40% (16 of 40 patients) had been seen daily, 28% (11 of 40 patients) had been reviewed between two and three days and 32% (13 of 40 Patients) were seen over three days. The trust recognised that the expectation was for daily consultant ward or board rounds as recommended by the Royal College of Physicians (RCP). The report recommended a further standardisation of consultant ward rounds within the medicine service which the service was in the process of addressing.

## Medical staffing

# Medical care (including older people's care)

- The trust had a yellow board scheme which was used when doctors required a clinical opinion from another speciality team as an important part of the patient's continuing management plan. Speciality referrals could be required in the following circumstances, for example:
  - As in integral part of an anticipated pathway of care
  - As part of an ongoing management plan, where advice from another expert field is of direct relevance
  - Where a patient required urgent speciality review due to an escalated significance such as suspected cancer.
- We saw the General Medical Council (GMC) survey report from Health Education England. The report identifies where Luton and Dunstable hospital stood relative to other trusts participating in the survey. Overall, the survey showed that the trust was performing better than other trust in key indicators such as; handover, induction, clinical supervision and local teaching.
- The hospital had a revalidation officer who ensured that all clinical staff requiring revalidation was completed.
- The trust had systems and procedures in place to support the process for all doctors who required revalidation. The aim of revalidation is to ensure that all doctors are up to date and remain 'fit to practise'. As of 31 March 2015, 108 doctors had been revalidated, 20 doctors have been deferred; with reasons accepted by the responsible officer and one doctor did not engage with the process and has subsequently left the trust.

## Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken by ward staff in the event of a utilities failure or major incident. Plans were available at ward level and via the trust intranet. These plans were familiar to most staff.
- Evacuation routes within the units were free of clutter and kept clear.
- Staff had attended mandatory training and had knowledge of procedures in the event of a fire. The records showed that 86% of staff had completed their training. This was above the trust target of 80%.
- The service had procedures in the event of a "black alert." A black alert occurs when a combination of the following factors occur:

- There are no available beds and predicted beds significantly fall short of those required.
  - Accident and emergency waiting time over two hours
  - More than 55 patients in the emergency department
  - Cancellation of elective cases due to capacity.
- During our visit staff within the endoscopy unit said their unit had been utilised for black alert three times during 2015. Senior said this had not impacted on their service and staff had the necessary skills to attend to patients allocated to the unit.

## Are medical care services effective?

Requires improvement



Overall, we found the effectiveness of medical services required improvement because:

- Generally, outcomes for patients were variable as compared to similar services.
- There was some participation in relevant local and national audits such as national diabetes and the heart failure audit but outcomes were mixed and whilst plans were in place to improve performance, progress was variable.
- Outcomes for patients having had a stroke were not generally optimal and the service was taking a series of actions to improve outcomes in this area.
- Plans were in place to provide a seven day service, but not all patients were being reviewed by consultants on a daily basis.
- The Hospital Standardised Mortality ratio (HSMR) was rising above the expected rate; the service was taking a series of actions to understand and address this issue.
- Staff generally had access to the patient's information on transfer for example; from EAU to a ward. However, in 12 of the 38 records read we found that the transfer forms had not been completed, as required, by the accepting ward.

However we found:

- The trust had effective evidence based care and treatment policies based on national guidance.
- Patients' pain was assessed and pain relief provided appropriately.

# Medical care (including older people's care)

- Patients' nutrition and hydration status were assessed and recorded on all the medical wards.
- We saw evidence of effective multidisciplinary working with staff, teams and services working together to deliver effective care and treatment.
- Staff had the necessary qualifications and skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience.
- Consent to care and treatment was obtained in line with legislation and guidance and, deprivation of liberty was applied appropriately.
- We saw where the medicine division had an audit plan. These included audits such as cannula and catheter insertion. The cannula and catheter insertion audits for December 2015 showed the service had achieved 92% compliance.
- The service had a clear pathway for the management of patients with suspected acute kidney injury, based on national guidance and this was one of the service's key strategy objectives for improving patient safety.
- The nationally recognised sepsis six care bundle was being used and audits carried out to ensure effective care and treatment was being provided.

## Evidence-based care and treatment

- On the stroke ward, patients' needs were assessed and care and treatment was delivered in line with the National Institute for Health and Care Excellence (NICE) quality standard CG58 Stroke: Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). For example, there was 24 hour access to a 'hyper acute' stroke facility. Staff used a validated tool to screen for a diagnosis of stroke or TIA. There was 24 hour consultant and nurse specialist support to attend patients admitted to the emergency department, a basic assessment of swallowing by the ward nurses on admission followed by a specialist assessment of swallowing within 72 hours of admission.
- Care pathways (multidisciplinary plans of anticipated care and timeframes) were in place for specific conditions or sets of symptoms. These included pathways for falls prevention and management, neutropenic fever and sepsis, malnutrition and delirium screening.
- There were integrated care pathways in place for all patients admitted to the cardiac centre. This ensured there were evidenced based care pre and post procedures for patients.
- The British Society of Gastroenterology (BSG) Guidelines for decontamination were available to staff via the trust intranet.
- Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff with a current access password.

## Pain relief

- Records examined showed that patient's pain relief was reviewed regularly and appropriate pain relief was given as prescribed when required.
- We saw the pain management action plan for October 2015. The key concerns identified that pain scores were not recorded consistently at every patient observation of vital signs. For example; where a patient with pain was identified by staff; 5% of patients reported that no action was taken, and where action was taken improvement was required by staff to return to the patient to check on the pain once an interaction had been undertaken
- Themes or issues identified included increased training and pain management awareness. We saw training/ learning guidelines were in place for nursing staff and doctors which were completed through the induction training. This was undertaken by the pain management nursing team and was an on-going programme.
- We reviewed 38 medical and nursing care records during our inspection and we saw where a patient's level of pain was recorded on the early warning score chart. We observed staff asking patients to rate their pain each time their physiological observations were taken. A review of 17 medication prescription charts demonstrated patients were given pain relief where appropriate at regular intervals.
- Of the 48 patients we spoke with none raised any concerns about the management of their pain.

## Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used in the wards and medical units. The MUST tool is a five-step screening tool to identify patients who are malnourished or at risk of malnutrition (undernutrition).

# Medical care (including older people's care)

The tool also includes management guidelines which can be used to develop a care plan. Patients who were nutritionally at risk were referred to a dietician. The records showed that all referrals had been responded to within 24 hours by the dietician. This meant that patients received appropriate treatment with regard to their nutritional needs.

- Patients' nutrition and hydration status were assessed and recorded on all the medical wards. The fluid balance charts audit for December 2015 found that 94% had been completed within general medicine. However, only 71% had been completed within elderly medicine. This was below the trust target of 80%. This meant there could be a risk of patients within elderly medicine not being monitored accurately to ensure that patients were properly hydrated. However, we observed that the fluid balance charts used to monitor patients' hydration within wards, especially the elderly wards, were completed fully within the records reviewed. The charts had the cumulative balance from the previous 24 hours. This meant that staff ensured that patients were drinking enough fluid that could help their recovery and prevent dehydration.
- The wards visited updated the dietary requirements of patients each morning. We saw the sheets which were given to the housekeeping staff highlighted what foods were suitable. Examples included soft foods, halal and diabetic foods. We checked the records for these patients and saw their dietary needs had been reviewed and highlighted.
- The cardiac centre which was used as an escalation ward did not have any hot food facilities for their in-patients. Patients were offered a choice from the menu and the hot meal were collected on trays from the kitchen.
- Patients told us they were offered a good variety of foods and drinks. A small amount of patients (seven out of 48) said they were disappointed with the quality of food provided. Two relatives said they brought in food for their relative due to the quality.
- Where there was any indication of a patient's difficulty in swallowing food or fluid staff followed a nil-by-mouth regime until an assessment could be carried out by a specialist practitioner. This meant patients could receive tube feeding with a nasogastric feeding tube within 24 hours of their admission.

- Modified meals; meals for patients who have difficulty chewing or swallowing, were available on the stroke unit.

## Patient outcomes

- The trust was closely monitoring the Summary Hospital-level Mortality Indicator (SHMI). SHMI is a score that reports on mortality rates at trust-level across the NHS in England, using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. We saw the SHMI data had remained steady at 102 (comparable to the national average of 100) throughout most of 2015. This was categorised "as expected" within the report.
- During 2015 the trust was closely monitoring the Hospital Standardised Mortality ratio (HSMR) through the mortality board. 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 mortality review update report for 2015 identified concerns as the HSMR was rising. We saw the figures for July 2015 were 113 against a threshold of less than 100. The results were RAG rated (red, amber, and green) and the trust had rated themselves as red. The trust had conducted a review of the HSMR in December 2015 which considered the patient's age profile, postcode and the number of patient's from nursing/residential homes. The results showed no apparent pattern identifiable.
- The trust had noted the recent increase in HSMR but with a stable SHMI. The mortality board met regularly to review mortality and initiated an in depth programme of work to analyse the current trend in mortality. This had been reported to the board. The trust told us that there were clear indications that their clinical coding was a contributory factor to the elevated HSMR, particularly regarding low palliative care coding. Therefore, the mortality board had recommended that the trust improved the documentation of both diagnosis/palliative care to ensure the most accurate coding of these cases.
- The mortality review update report for December 2015 outlined how the trust was going to review the risk. This included a review by an external expert to quality assure the work done by the trust. This was due to completed in February 2016.

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- The medicine service took part in the Sentinel Stroke National Audit programme (SSNAP). Luton and Dunstable Hospital had consistently shown an overall score of E from July 2014 to June 2015. This was the lowest score possible. The trust had identified the risk to the patients and had set up an action forum to review the outcomes of the SSNAP audit. We saw the action plan with identified targets for March 2016, which included ring fencing beds to improve flow, prevent admissions to non-stroke beds, enhancing speech and language therapy provision (provided by another trust) and improved therapy input for patients in non-stroke beds. Actions were being monitored by the stroke forum and supported by the clinical commissioning group (CCG).
- The records showed that the stroke data for July 2015 was invalidated. Due to this the trust and the CCG established a stroke forum in October 2015 to improve the overall performance. We saw the action plan for 2015/16 which identified the SSNAP domains. The performance identified was red, amber and green (RAG) rated. Examples for red included the percentage of patients admitted directly to a stroke unit within four hours of clock time. The quarter one (April to May) target showed a shortfall of 4% and a shortfall of 3% for quarter two (June to August). Actions for improvement included increasing the capacity of stroke beds. We saw the trust had implemented this action by increasing the stroke bed capacity by eight beds.
- A new standard operating procedure had been introduced for wards 16 and 17. This meant that all stroke patients were admitted directly to ward 17 until a stroke diagnosis was excluded whereby patients stepped down to ward 16. Further actions included the validation of the data and the appointment of two new consultants. Senior staff said that all actions would be reviewed at the stroke forum.
- In data provided by the trust for the period July to September 2015, we saw that the service had also improved the average minutes of occupational therapy and physiotherapy time per day for stroke patients to approaching 50 minutes per day; this represented a significant improvement on previous periods.
- The stroke service had participated in the CLOTS 3 trial. This was a randomised trial to establish the effectiveness of Intermittent Pneumatic Compression (IPC) to prevent post stroke deep vein thrombosis (DVT). The outcome of the trial showed that IPC was an effective and inexpensive method of reducing the risk of DVT and improving survival in immobile stroke patients. The stroke service had implemented the use of IPC within its service.
- The trust provided a 24 hour stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain). The trust standard was that all patients admitted following a stroke were thrombolysed within one hour of clock start. The records for quarter one and two (April to September 2015) showed a shortfall of 6%. Actions identified included the pre-alert protocol for a computerised tomography (CT) scan to be implemented to minimize delays. A CT scan x-rays the body from different angles to build up detailed images of the inside of the body. Staff described the process which had been implemented.
- The trust met the target for patients with high risk of a transient ischaemic attack (TIA) being treated within 24 hours. A TIA or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain.
- The trust took part in the National Diabetes Inpatient Audit in 2013, and performed worse than the England average in 13 out of 21 indicators. We saw the completed action plan which addressed identified concerns. Areas identified included; diabetic menu choices available on all meals and qualified and non-qualified nursing study sessions on diabetes. This equates to over 60% of all indicators being worse than the England average. The trust did not participate in the 2014 audit due to a delay in upgrading the diabetes computer system. This was recognised on the risk register and we saw that the diabetes computer system was due to be operational in April 2016.
- Based on the 2013/2014 audit, the trust told us key areas for improvement were identified for the service that formed an overarching improvement plan. This plan focussed on key investments such as:
  - An increase in the Clinical Nurse Specialist team to improve ward presence and specialist advice.
  - Implementation of electronic drug prescribing to improve prescribing and reduce error
  - Further investment in training and development for all clinical groups.
- The trust provided us with a copy of their National Diabetes Inpatient Audit for 2015. This is due to be published in June 2016. The audit reviewed 509 beds of

# Medical care (including older people's care)

which 95 were identified has having diabetic patients and showed improved performance compared to the previous audit. The audit identified that there were protocols in place for the monitoring of blood glucose levels. However, there was no policy for the self-management of diabetes. This was confirmed by senior staff when visiting the wards. The hospital had systems in place to increase the number of inpatients with diabetes who have a food examination. The hospital had a diabetic specialist nurse (DSN) and specialist podiatrist. This service was available Monday to Friday. Although not available to the service, they had access to a vascular surgeon, tissue viability nurse, microbiologist and interventional radiologist.

- The trust took part in the 2013/14 Heart Failure Audit (published October 2015). The trust scored similar to other trusts for the majority of indicators such as patients being seen by a cardiologist and patients that were referred for or had an angiogram. The trust scored 100% for patients receiving an echocardiogram. An echocardiogram is a scan used to look at the heart and nearby blood vessels. The trust also scored high at 90% for patients receiving a discharge plan. However, the input from a consultant cardiologist was at 48% and the follow up from a heart failure nurse was at 49%. Also only 9% of patients were admitted to a cardiac unit or ward compared to an England average of 55%. The trust had improved all scores in the 2013/14 audit compared to the 2012/13 audit. The monthly cardiology business reviewed the performance and audits within the service. We saw the actions and the person responsible. These had been reviewed monthly within the minutes seen.
- In the national Myocardial Ischaemia National Audit Project (MINAP) 2013/14 which reviewed the treatment and care of patients who had suffered a heart attack. The trust performed better than the England average for patients seen by a cardiologist and patients that were referred for or had an angiogram. An angiogram is a test that shows if blood vessels which supply blood to your heart, are narrowed or blocked. However, there was no data available for thrombolytic door to needle time for the hospital. The trust had overall improved all scores in the 2013/14 audit compared to the 2012/13 audit.
- The trust had achieved the Joint Advisory Group (JAG) accreditation. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised. We saw the JAG report

for October 2015. We saw the issues identified and the responded action which included an audit of the 30 day mortality and the responded action which incorporated the result of a survey carried out.

- The risk of readmission was lower than the England average of 100 for elective admissions and similar to the England average for non-elective admissions with the exception for non-elective respiratory medicine which had a score of 151 compared to the England average of 100.
- The Royal College of Physicians' Inpatient Falls Audit report was released in September 2015. The report found that across England and Wales, the mean rate of falls per 1000 bed days was 6.63, the hospital rate was better at 5.49. Rates of falls resulting in moderate or severe harm across England and Wales was 0.19, the hospital rate was better at 0.14. Assistive technology to minimise falls was being used following a risk assessment process.
- We saw the divisional action plan for the directorate of medicine and elderly care as of November 2015. The action plan identified the areas for improvement, the action required and the timescale. Examples included; the de-cluttering of the wards and the review of the environment and equipment. The action plan had a review date of March 2016.
- The service had an audit plan for 2015 to 2016 which detailed all the national and local audits the service was taking part in, including the National Adult Diabetes Audit, the National Lung Cancer Audit, the Sentinel Stroke National Audit Programme (SSNAP), and the National Audit of Dementia (NAD).

## Competent staff

- Staff told us they had regular annual appraisals, but did not receive formal supervision. They said they received appropriate ad hoc support from their colleagues and felt that handovers, ward rounds and board rounds provided them with learning opportunities. The records showed that as of 20 January 2016, 85% of staff had received an up to date appraisal. This was slightly less than the trust's target of 90%.
- We spoke with two new staff members who confirmed they had been allocated a mentor and would be working with them throughout their induction period. They confirmed they had received a competency handbook which they were working through. We saw a

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copy of the induction handbook which identified input from the staff's mentor. New staff also confirmed they saw the clinical educator weekly and said they felt "well supported."

- Senior staff on the wards visited said there was a good leadership programme available for all Band 7 nurses. Staff currently undertaking the programme said that it was very good and they felt proud to be given the opportunity to develop within the trust.
- The education department confirmed that they worked alongside the human resources team to ensure that all agency nurses had the appropriate training prior to being employed by the trust. This was confirmed in the records reviewed on the wards.
- The trust worked in partnership with a local Sixth Form College to select six young people who aspired to study medicine. Each of the mentees were matched with a consultant. Senior staff within the DME said they utilised the services of the sixth form college and found it to be very beneficial.
- Clinical staff within the medical division had completed the Acute Life Threatening Events Recognition and Treatment (ALERT) training. ALERT is a multi-professional course to train staff in recognising patient deterioration and act appropriately in treating the acutely unwell.
- Staff within the medical division had completed the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH). BEACH empowers care assistants and clinical support workers with the skills and techniques required to recognise and escalate a deteriorating patient.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs. We saw completed training workbooks which had been reviewed, dated and signed by senior staff. This meant that staff had support across the service in completing their local induction from experienced staff.
- Nurses on the stroke ward were competent in completing basic swallowing assessments, which meant that patients were assessed quickly and able to eat if it was assessed as being safe for them to do so.
- The cardiac centre was staffed by nurses and physiologists; staff with expertise in monitoring heart and blood pressure readings, radiographers and, cardiology consultants. All staff in the cardiac centre were trained in immediate or advanced life support; these are specialist qualifications in resuscitation.

- The revalidation officer ensured that all clinical staff requiring revalidation had been completed. This meant that staff had the necessary skills to manage the care and welfare of patients.

## Multidisciplinary working

- There was an effective multidisciplinary team (MDT) approach to planning and delivering people's care and treatment. We saw involvement from nurses, medical staff, allied health professionals and the social work department. All staff we spoke with told us that there were good lines of communication and working relationships between the different disciplines.
- The records showed good multidisciplinary input from occupational therapists, physiotherapists and speech and language therapists. There was clear communication to the therapists and we saw the agreed decisions and actions.
- We observed good communication between the doctors and the therapists regarding a patient's discharge. The conversation considered different options for the patient and their relative. There was good effective team working with the patient as the focus of their discussion.
- In stroke services MDT meetings were held daily Monday to Friday. Daily 'board meetings' were held in all other areas to review patients' care pathways; we reviewed a sample of these meetings. The patient's progress was discussed and included any discharge plans.
- On the EAU's there were robust systems in place to ensure all team members were aware of who had overall responsibility for each patient's care. The patients' had allocated doctors to oversee their care every morning. Dependant on the patient's diagnosis the most appropriate consultant would be allocated to review the patient. To ensure continuity of care, the same doctor/consultant would see the same patient each day if they remained on EAU.
- We saw the guidelines for out of hours cover for escalation areas. The medical cover consisted of an acute physician on site until 22:00hrs daily (including weekends and bank holidays) then two medical registrars managing the acute medical intake and any ward reviews. The trust had recognised the safety risk to the two registrars regarding the additional workload by ensuring there was additional cover for escalation levels two to seven. Examples included on call medical/division of medical elderly (DME) consultant on site from midnight plus and an additional junior to be made

# Medical care (including older people's care)

available to support for levels two to six. All consultants to be available to participate in level seven escalations. We visited the cardiac centre and ward 22a (both escalation wards during our visit) and found no issues in the records read regarding medical cover for patients.

- Where it was identified that a patient had significantly deteriorated there were procedures in place to provide specialist advice.
- There were processes for accessing mental health services. Staff had access to mental health teams to review patients.

## Seven-day services

- On the wards consultant reviews were inconsistent with some wards reporting daily review of patients by a consultant and others reporting twice weekly reviews. The report recommended a further standardisation of consultant ward rounds within the medicine service which the service was in the process of addressing.
- The records showed that a consultant conducted a post-take ward round and reviewed every patient within 24 hours of admission to hospital. For example; on the elderly wards visits the records identified that all new and deteriorating patients were seen by the on-call care of the elderly consultant.
- Nursing staff and junior doctors told us consultants were on-call out of hours and were accessible when required.
- The patients on the coronary care unit (CCU) and cardiac centre were seen daily by the cardiology consultant. All new and deteriorating patients were seen either by the consultant or the medical registrar during the day time, and were seen by the on-call consultant over the weekend.
- Each ward visited had an integrated discharge team who provided a seven day a week service. The aim of the discharge officer was to:
  - Co-ordinate simple and complex discharges
  - Liaise with patients, family members and staff
  - Ensuring and referencing consent with external agencies
  - Work alongside the social workers department to provide joint working for example; housing, mental health concerns and linking with charities.
- Allied health professional including occupational therapists, dieticians and, speech and language therapists worked Monday to Friday. On the stroke unit

this had been highlighted as an issue with the rehabilitation of patients following a stroke and senior staff. The stroke unit had increased to a seven day service of an MDT member every weekend.

- A seven-day integrated discharge team was available on each ward visited. Staff told us this enabled access to community services at the weekends.
- The pharmacy team provided a seven day service. They worked Monday to Friday 8am to 5pm and to 5:30pm in the dispensary service. On Saturday and Sunday they provided a service 10am to 3pm. An on-call pharmacist was available to give advice out of these hours.

## Access to information

- Staff said they had good access to patient related information and records whenever required. The agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Staff had access to the patient's information on transfer for example; from EAU to a ward. We observed staff receiving a handover of a patient's medical condition and ongoing care information was shared appropriately. However, in 12 of the 38 records read we found that the transfer forms had not been completed, as required, by the accepting ward. We raised this with the trust, who took immediate action to address this issue.
- Information needed to deliver effective care and treatment was available to most staff in a timely and accessible way. Procedure specific information, policies and procedures were available via the trust intranet.
- Additional information relating to current trust issues, incidents and complaints was available to staff via communication boards, a serious incidents folder and, through staff meeting minutes.
- Patient discharge summaries were sent electronically to the patient's GP on discharge to ensure continuity of care within the community.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The safeguarding lead and the dementia nurse specialist provided Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) training to staff. They ensured that staff had an understanding of MCA and DoLS. They were able to support staff in the interpretation of the legislation.

# Medical care (including older people's care)

- We saw consent to care and treatment was obtained in line with legislation and guidance. We saw three patients receiving care whilst being deprived of their liberty. We saw that the orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- The training records identified that 90% of nursing and medical ward staff had completed the MCA and DoLS training. This was in line with the trust's target.
- Senior staff within the medical wards understood how to act when restriction or restraining might become a deprivation of liberty. We did not observe any instances in medical services where an application should have been considered at the time of our visit.
- The trust did not have an audit process for the review of MCA assessments. The assurance regarding process and quality was gained through:
  - Specific training and education for clinicians to undertake MCAs
  - Involvement of the safeguarding lead nurse for complex decisions relating to mental capacity
- DoLS applications were made for patients who were:
  - Attempting to leave the ward
  - Refusing essential medical and nursing care
  - Requiring one to one supervision to maintain their safety.
- A database of all DoLS applications was maintained by the adult safeguarding team and the relevant medical and nursing teams who were updated with the on-going outcomes of the process.
- The adult safeguarding team reviewed all the DoLS authorisations on a daily basis.
- During our unannounced inspection, we saw evidence of a DoLS authorisation form which had been appropriately completed in accordance with trust policy.
- Patients received compassionate care, and patients were treated with dignity and respect. We saw that staff interactions with patients were person-centred and unhurried. Staff were focused on the needs of patients and improving services.
- Patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them.
- The data from the friends and family test (FFT) was positive with 87% stating they had no problem with the service provided.
- There were arrangements to provide emotional support to patients and their families where required.

## Compassionate care

- We spoke with 48 patients and five relatives during our inspection. Feedback was generally positive with patients and relatives commenting on how well the care staff looked after them.
- During our inspection we observed staff to be polite and courteous to patients. We saw staff responding compassionately when patients needed support and saw a number of examples of good care. For example; on ward 15 we saw a patient becoming distressed regarding the taking of medicines. The staff took time to explain each medicine and what they were for. They ensured the patient took their time in swallowing the medicines.
- Staff generally respected people's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- Confidentiality was generally respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.
- Three patients on ward 17 said night staff could be "brusque" and did not like patients getting out of bed. This was brought to the attention of the nurse in charge who took immediate action to address this concern.
- We reviewed the NHS Friend and family Test (FFT) results for the medicine service for period between April 2014 and September 2015. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The overall FFT score during this

## Are medical care services caring?

Good 

Overall, we rated the care provided to patients in medical care services as good because:

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period was 81% (469 responses). This was below the national average recommended score of 96%. We saw that 73% of patients said they would rate the communication from doctors and 87% said they did not experience any problems with the quality of care or treatment.

- The Healthwatch inpatient report for 2015 showed that 84% of patients (496) scored their overall inpatient experience as good or excellent. 92% of patients rated the nurses as good or excellent and consultants were scored as good or excellent by 85%.
- The trust took part in the 2014 Cancer Patient Experience Survey (CPES). CPES, run by Quality Health, provides insights into the care and treatment experienced by cancer patients in 153 NHS hospital trusts across England. Luton & Dunstable Hospital was in the top 10 most significantly improved trusts for 2014. The CPES showed consistent improvements across many areas, especially verbal communication, written information and having confidence in ward nurses. There were some areas where progress was still needed. These included care planning with 44% of patients not fully informed about side effect that could affect them in the future and 78% were not offered a written assessment and care plan. Patients (60%) said that doctors and nurses asked what name they preferred to be called by.
- The patient experience results (February 2015) released by Macmillan Cancer Support, based on research commissioned by NHS England showed the hospital was among the top ten for patient experience across England. Patients said the care they received was "among the best" they'd received.
- We saw the results of the 2014 (released August 2015) annual PLACE (Patient Level Assessments of the Care Environment) report. The PLACE report showed the trust scored close to the national average for respecting patients' privacy and dignity.

## Understanding and involvement of patients and those close to

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.
- Patients told us the doctors had explained their diagnosis and that they were aware of what was

happening with their care. None of the patients we spoke with had any concerns with regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.

- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- All staff we observed communicated respectfully and effectively with patients.
- During our inspection we observed a medical handover taking place by the patient's bedside. The beds were very close to each other and information being shared could be overheard by other patients. We raised this with the nurse in charge.
- The handover information was of a sensitive nature for example, if the patient was for resuscitation, information about pressure areas and continence needs. We observed the medical staff communicated well and included the patients in the dialogue.
- Most patients told us they felt involved in the decision making process regarding their care. Feedback from relatives reported consistent communication from the medical staff and they knew about the care and discharge arrangements.

## Emotional support

- Most staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workload meant this did not always happen.
- Patients said the hospital chaplaincy had a visual presence around the hospital and they were happy to meet them.
- Clinical nurse specialists were available for advice and support in a number of specialties including stroke services, cancer services and for heart failure patients.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.

# Medical care (including older people's care)

## Are medical care services responsive?

Good



Overall, we rated the responsiveness of medical care services as good because:

- Medical services were generally responsive to patients' needs.
- Effective use of escalation areas supported appropriate patient flow despite high demand for beds.
- The trust consistently met the 90% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment.
- The number of bed moves of more than one was low within the hospital.
- The trust's average length of stay was lower than the England average for elective admissions.
- There was support for vulnerable people, such as people living with dementia and mental health problems.
- We saw there were systems in place to monitor medical outliers effectively throughout the trust.
- Complaints were generally handled in line with the trust's policy and were dealt with effectively.

However, we also found that:

- There was a shortfall at times across the medical service for therapist input. However, this was monitored monthly and any deterioration in the provision of patients' therapy discussed.
- Whilst there was a discharge team focusing on timely discharges, some patients remained longer than intended on the ward and the trust did not have a true reflection of extended length of stays for all specific wards.

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

- The service generally understood the different needs of the people it serves and acted on these to plan, design and deliver services.
- The hospital had an ambulatory care service. Ambulatory care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital. You will receive the same medical treatment you would previously have received

as an inpatient. The areas covered within the hospital included; gastroenterology, infection, neurology, stroke medicine and thromboembolism (obstruction of a blood vessel by a blood clot). Patient's needs had been met in the design and planning of the service. Despite issues with access and flow due to bed pressures in the hospital, the medical services were responsive to emergency admissions.

- The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patient's home in a timely way. The trust's hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community teams such as the rehabilitation team and the stroke team to improve discharge arrangements.
- Planning the delivery of the service was coordinated at daily bed management meetings.
- The service had undertaken a 'first impression on entering the ward' review for ward 16 and 17 to ensure the ward was a dementia-friendly environment. Areas looked at included the flooring to ensure it contrasted with the walls and furniture and good signage. During our visit to the ward we observed good signage within the toilets and bathroom facilities and a large face clock which was clearly visible.
- Bed spaces were capable of giving reasonable visual privacy. We observed nursing stations on ward 19b being at the end of each ward to facilitate patient observations.
- The service was working closely with local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community.

### Access and flow

- Between December 2014 and November 2015, the trust consistently met the 90% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment. Each specialty within medicine individually achieved above the 90% target for the 12 month period.
- We saw the trust had developed an escalation plan to enable patients to be assessed, treated and managed in a safe environment during episodes of surge in activity. The trust had recognised the risks associated with the management of patients spread over a number of wards

# Medical care (including older people's care)

and had introduced a model to improve the management of medical and the department of medical elderly (DME) outliers. Medical teams were allocated to the escalation wards which evened out the workload and improved patient tracking. Examples included; gastroenterology to ward 22a and acute admissions to the cardiac centre.

- The escalation plan supported patient safety during increased attendance to the hospital. The aim of the escalation plan is to assess the risk to patient safety through advanced planning, early escalation and clinical engagement. This enabled the hospital to escalate in a responsive way but also to de-escalate quickly and any identified concerns.
- Part of the advance planning was to staff three contingency areas with permanent staff. Wards 19a, 19b and 22a were fully funded and staffed. A substantive band 7 nursing staff had been recruited to manage the contingency areas to ensure consistent leadership and optimum standards of care. In addition to this, the escalation plan enabled patients to be assessed, treated and managed in safe escalation environments during episodes of surge in activity. Areas that had been risk assessed for use within the medical service included the cardiac centre (six to nine beds) and the endoscopy ward (four beds).
- All patients that were assessed and underwent therapy from both the physiotherapy and occupational therapy were added into a data base. Each month two patients were randomly selected from each ward and their medical records reviewed using the therapy admission log. This was monitored monthly and any deterioration discussed. We saw the records for December 2015 which showed the percentage of patients with care plans in place and who had been reviewed by the therapists. The results were RAG rated. The records for the DME, respiratory and medicine showed that the physiotherapy input was rated as red. The results were 58% for respiratory and medicine and 67% for DME whilst the occupational therapists showed 92% input for respiratory, 86% for medicine division and 42% for DME. This meant that patients may not receive the necessary therapist input to assist in their rehabilitation. This was monitored monthly and any deterioration in patients' therapy provision was discussed.
- The standard operating procedures for ward 3 (female medical short stay) said the aim of the ward was to provide medical care of patients who can be "treated

within 72 hours and if required, when stable, treatment is carried out in the community." We found many instances of patients with complex speciality problems having protracted stays. For example, we found seven patients on this ward who had been there for longer than five days. The standard operating procedures provided no guidance to the staff team on how to escalate stays longer than 72 hours. Patient's needs were being met whilst on the ward and the bed management team oversaw the availability of inpatient beds and liaised with the discharge team regarding facilitating community care support packages for these patients.

- We reviewed the data for the number of bed moves within the service for 2015. For example within elderly medicine the number were:
  - One move equated to 52% (24 patients out of 46)
  - Two moves equated to 15% (7 patients out of 46)
  - More than three moves equated to 11% (5 patients out of 46)
- Eleven patients (27%) within general medicine had a single re-admission to the hospital within 30 days, whilst there were nine patients (20%) from elderly medicine readmitted to the hospital within 30 days. Eight of the nine patients from elderly medicine had single re-admissions and one patient had two re-admissions within 30 days.
- During our inspection we reviewed five medical outliers across three wards. Medical outliers are where patients are receiving care on a different speciality ward. We saw there were systems in place to monitor medical outliers throughout the trust.
- Nursing staff on these wards told us outliers were reviewed on a daily basis by the ward doctors but had access to specialist consultants when required.
- We reviewed the medical records of all five patients and saw, where applicable, patients had received a further medical review within 12 hours of their admission to the trust.
- The trust's average length of stay was lower than the England average for elective admissions. At speciality level the trust had a particularly higher length of stay for non-elective respiratory medicine admissions. We saw the length of stay between one day and four weeks for 2015. For example; 48 patients (10%) had a length of

# Medical care (including older people's care)

stay of one day whilst 44 patients (9%) had remained in the hospital for over four weeks. The records showed that the length of stay was mainly due to the availability of a package of care for patients.

- Senior nursing staff we spoke with told us discharges did not always happen in a timely way. However, there were fewer problems with medicines to take home. To assist in the progress of timely discharges the integrated discharge team were involved in discharge meetings and, commenced continuing healthcare documents.

## Meeting people's individual needs

- People who used the service were asked about their spiritual, ethnic and cultural needs and their health goals, as well as their medical and nursing needs.
- The dementia nurse specialist for Luton and Dunstable hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gives staff an experience and insight to what it is like living with dementia. The nurse specialist said this was very popular and gave staff an understanding of people's individual needs.
- Senior medical staff within the DME said the hospital was aiming to launch the "John's Campaign" by May 2016. The aim of the campaign is to give the carers of those living with dementia the right to stay with them in hospital.
- The needs of people living with a dementia were generally detailed in care plans and were person centred.
- The hospital provided dementia link nurses on most wards to help support effective care for people living with a dementia. The hospital used the "This is Me" documentation books that, when completed by patients and their families, gave person centred information to staff to facilitate more effective care.
- The needs and wishes of people with a learning disability or of people who lacked capacity were understood and taken into account.
- A learning disability specialist nurse was available in the trust. Staff told us the nurse would be aware of the patient's admission and would visit the patient to offer support and advice.
- We saw pictorial signs which helped those patients living with dementia to interpret the different areas of the ward and therefore help them to find their way around.
- The trust had access to mental health advisers who could provide support, guidance and review patients as required.
- We noted during our inspection patient information leaflets in clinical areas and on the trust website were available in other languages. Nursing staff said the leaflets could be translated into other languages, not identified, if required.
- Interpreters were accessible either face-to face or via a telephone service, All the staff we spoke with told us the interpreting services were easy to access.
- There were facilities for patients who were well enough to have a shower or use a toilet.
- Patients were referred to the cardiac centre as and when required. We found that the unit did not have shower facilities. We asked patients how they felt about not having any shower facilities. One patient said "you just have to put up with it" and another said "you have no choice." Patients could access the shower facilities on an adjacent ward if required. However, this meant that a nurse from the cardiac centre had to escort the patient which could leave the unit short staffed.
- Visiting times could be flexible to allow for relatives of elderly patients to maintain family contact throughout long periods of admission.
- Some wards, patients had access to activity kits for meaningful stimulation.
- Some wards had quiet areas for discussion with patients and relatives. Wards had access to a chapel and multi faith room on site.
- We saw cultural information files available, with details of religions and their naming conventions, beliefs, rites and rituals and end of life beliefs. Staff said they had had training and support in this area.
- Five of the patients we spoke with commented on the 'lack' of nursing staff on duty resulting in delays in answering call bells and attending to patient's needs. However, during our visit to the service we observed the call bells being answered promptly with no delays identified.
- A 'red tray' system was in place at the hospital to ensure that the nutritional requirements of patients were fully met. Patients who needed help with eating were served meals on red trays and those who needed encouragement with their fluid intake to prevent

# Medical care (including older people's care)

dehydration were given a water jug with a red lid. During our inspection we saw where patients with either a red tray or, a water jug with a red lid were offered the appropriate level of assistance.

- Staff said there were no concerns in obtaining plates and beakers to support patients with their nutritional requirements. However, they were unable to access adapted cutlery. Staff said patients required an occupational therapist assessment prior to being able to request the appropriate cutlery.
- We saw the results of the 2014 (released August 2015) annual PLACE (Patient Level Assessments of the Care Environment) report. The service did not perform so well for food, condition and dementia care. We saw an improvement plan had been developed which was being monitored by the PLACE committee.

## Learning from complaints and concerns

- Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.
- Complaints procedures and ways to give feedback were in place.
- People were supported to use the system and to use their preferred communication method. This included enabling people to use an advocate where they needed to. People were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures.
- The trust reviewed and acted on information about the quality of care that it received from patients, their relatives and those close to them and the public.
- Staff said they directed patients to support services if they were unable to deal with their concerns directly and advised them to make a formal complaint.
- We saw the majority of complaints within the medicine service related to noise within the wards. Three patients on ward 17 and ward 3 commented on how noisy the wards got in the evenings. This was identified on the patient's quality and information board. Senior staff said they aimed to keep the wards as quiet as possible and were aware of the patient's concerns.

- Staff would speak to anyone raising a complaint at the time they raised it. Senior managers were also available to talk to anyone with a concern or complaint. The aim was to try and resolve the problem or complaint at the time it was raised.
- Literature and posters were displayed advising patients and their relatives how they could raise a concern or complaint, formally or informally.
- Staff told us ward matrons investigated complaints and gave them feedback about complaints in which they were involved.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.

## Are medical care services well-led?

Good



Overall, we rated the leadership of medical care services good because:

- Staff and service leads were generally clear about their priorities and vision for the service.
- There was good feedback from patient's surveys. Relatives said they saw staff treating patients with respect and were happy with the service provided.
- Motivated, accessible and experienced consultants and team managers oversaw the running of the medicine service. Staff said that consultant and doctors were supportive.
- Communication, morale and working together as a team had improved and they enjoyed coming to work. Staff within the medicine service said the non-executive directors often visited the unit.
- The staff survey results showed staff felt satisfied with the quality of work and patient care they were able to deliver. Daily safety huddles meant that staff had all the relevant information to support patients within the service.
- Staff felt supported by their ward and line manager. Staff delivered quality care and excellent patient experience.
- This was an innovative service with staff feeling empowered to suggest new ways of working.

However, we found that:

# Medical care (including older people's care)

- Whilst the service had generally recognised the risks to patient safety and the quality of care and treatment, actions were not always clearly defined and therefore progress was variable.
- Learning from mixed performance at national audits was not always effectively used to drive forward improvements in a timely manner.
- Some staff said they felt the pace of change had been implemented too quickly and they needed time to ensure recent changes had been fully embedded.

## Vision and strategy for this service

- The service leads were generally clear about their priorities and had a long-term strategy for the division. The vision of the service was to continuously improve the quality and to accept responsibility for our actions, individually and collectively.
- The Operational Plan document for 2015/16 outlined the “key deliverables” which the hospital believed was fundamental to the continued delivery of Operational Performance. Examples included:
  - Implementing a robust workforce plan
  - Reducing the number of patients who are medically fit for discharge
  - Sustaining performance against national quality and performance targets.
- The trust had established three clinical safety priorities for the hospital as part of the national NHS Sign up for Safety campaign:
  - Improving the management of the deteriorating Patient
  - Improving the management of patients presenting with acute kidney Injury (AKI)
  - Improving the management of patients presenting with sepsis
- We saw the trust's values on display within the wards. Staff described the trust's values and the service's strategy which included putting the patient first.
- Ward sisters and therapy staff were passionate about improving services for patients, and providing a high quality service.
- Some staff said they felt the pace of change in recent months had been implemented too quickly and they needed time to ensure that recent changes were fully embedded into the service.

## Governance, risk management and quality measurement

- The service had recognised the risks to patient safety and the quality of care and treatment provided and were putting actions in place, for example, establishing the stroke forum to review performance and learning from the SSNAP audit.
- The service was implementing actions plans to address these areas of risk, but progress in meeting these plans was variable. For example, the service had recognised the poor VTE assessment completion and the lack of daily consultant review as risk areas but it was not clear to assess the swiftness of the response as some plans were a work in progress with outcomes not always clearly identified.
- There was some progress in working towards providing a seven day service but timescales were not always clearly defined in terms of managing this transformation.
- Ensuring all staff had had the required safeguarding children training at level three had proved problematic as the service was reliant on an external organisation to deliver this training: this meant there had been delays in ensuring all relevant staff had had this required training.
- Senior staff attended monthly meetings which were held by the chief nurse. Staff said this was an opportunity to share practices across the service and feedback to the wards.
- The medicine service attended monthly clinical governance and assurance meetings. Areas covered included; clinical incidents, risk register, NICE guidance compliance, training and complaints. We saw reviewed actions and outcomes were identified.
- The service had meetings whereby information from the hospital clinical governance team was cascaded to staff. This included information on incidents and audits. Newsletters, emails, discussions at handovers and one-to-one meetings were evident for staff who could not attend staff meetings. Staff confirmed they received information about issues relating to the unit, division and the trust as a whole.
- The medical services had a quality dashboard for each service, and this was available on the trust's intranet site. It showed how the services performed against

# Medical care (including older people's care)

quality and performance targets. Members of staff told us that these were discussed at team meetings. The ward areas had visible information about the quality dashboard.

- Divisional governance meetings took place monthly. During these meetings, risks and actions were identified to reduce risk and improve patient safety. Minutes we reviewed demonstrated discussions around current risks for the division, patient safety, patient experience and, clinical effectiveness.
- The medicine service risk register identified areas of concern with monthly reviews. We saw there were actions and controls in place. The register accurately reflected the risk within the service.
- All wards had visible performance boards on display, for patients and their visitors, which showed performance against key risks areas, current staffing levels, and other information, such as how individual wards were performing on the Friends and Family Test (FFT) surveys.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.

## Leadership of service

- Members of the divisional, local and trust leadership teams were visible. Most staff were aware of the role and functions of key board members and could identify them for example the chief nurse and chief executive officer.
- Senior staff attended monthly meetings which were held by the chief nurse. Staff said this was an opportunity to share practices across the service and feedback to the wards.
- Staff said they attended the engagement events held by the trust which they felt was very good as it updated them of what was going on in the trust.
- Ward staff told us that senior nursing staff, consultants and doctors could be seen on the wards and they were approachable and helpful.
- Staff said morale was very good and that staff worked well together as a team. For example, the stroke service had four daily huddles which staff said helped them to bond as a team.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division, and in the trust.

- The student nurses told us they felt supported on the ward and received good mentoring and training from the senior staff. They told us consultants were accessible and approachable.

## Culture within the service

- There was a whistleblowing process for the trust. Staff knew of the trust's whistleblowing policy and said they would be confident in using it if required.
- We observed staff being positive about working for the trust. Staff felt committed to providing good quality care and understood the contribution they made personally to the care and treatment of patients. Ward managers said the high use of agency nurses was their biggest concerns.
- All of the ward managers we spoke with said they were proud of their team.
- Staff we spoke with told us they felt there was a culture of openness within the organisation. For example during our visit a ward manager contacted the chief nurse about an issue she wished to discuss and the chief nurse attended the ward shortly after. A nurse we spoke with told us she considered that this was typical of the organisations' approach. They explained their interactions with the chief nurse were positive about the interest they showed in their wards
- Staff in the cardiac centre reported good mutual support and team morale.
- Some clinical support workers felt that work pressures had increased, as their workload was rising due to the increased dependency of patients.
- Staff spoke positively about the high quality care and services they provide for patients, and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- We spoke with the education team who confirmed they worked alongside the ward manager to:
  - Develop the ward by reviewing the actions for improvement
  - Would support the ward for a dedicated period of time
  - Once the ward was stable the educator would withdraw their service

# Medical care (including older people's care)

- Reassess the ward and if required provide additional support.
- We saw the sickness rate for the medicine division. This was just above the trust target of 3% at 4%. Senior staff described how there were return to work incentives to support staff. The service had access to the occupation health service.

## Public engagement

- During our inspection, we saw a number of cards and letters from patients and their relatives thanking staff for the care they had received.
- The junior doctors told us they were able to raise concerns, and the trust conducted junior doctor forums, where they could express their views and share new ideas.
- Patients were engaged through feedback from surveys, such as the NHS Friend and Family Test, the Cancer Patient Experience Survey (CPES), and from complaints and concerns. Clinical governance meetings showed patient experience data was reviewed and monitored.

## Staff engagement

- We spoke with 43 staff members from a variety of roles. Most staff were engaged and felt able to raise concerns and felt empowered to suggest new ways of working within their areas.
- Staff said that having the board meeting minutes available helped them to understand more about the hospital and how it was performing.
- Staff said they were aware of the trust's incentive to recruit more nurse to improve permanent staffing levels.
- We saw the national staff survey for the hospital for 2014. The survey score ranged from one to five. The trust achieved a score of 3.79 which was above (better than) average (3.74) when compared with trusts of a similar type. The hospital scored better (84%) than the national

average (81%) for example; the percentage of staff receiving job-relevant training, learning or development in last 12 months. However, the trust scored below the national average (77%) for the percentage (71%) of staff working extra hours.

- Staff on EAU2 said there were many challenges to the unit as recently they had amalgamated three areas into one. On EAU2 they had merged the emergency assessments, cardiac service and medical patients. Senior staff said the structure was still new and they were looking an updating the standard operating procedures policy to reflect the changes.

## Innovation, improvement and sustainability

- We were informed that new ideas and innovations were encouraged and the leadership team was open to testing them where possible. The stroke service had participated in the CLOTS 3 trial. This was a randomised trial to establish the effectiveness of Intermittent Pneumatic Compression (IPC) to prevent post stroke deep vein thrombosis (DVT). The outcome of the trial showed that IPC was an effective and inexpensive method of reducing the risk of DVT and improving survival in immobile stroke patients. The stroke service had implemented the use of IPC within its service.
- The dementia nurse specialist for Luton and Dunstable hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gives staff an experience and insight to what it is like living with dementia. The nurse specialist said this was very popular and gave staff an understanding of people's individual needs.
- The hospital received a Macmillan Quality Environment Award in February 2015 which assessed how well the hospital buildings such as chemotherapy units provided support and care for people affected by cancer.

# Surgery

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

## Information about the service

Luton and Dunstable University Hospital NHS Foundation Trust provides surgical services to the population of Luton, South Bedfordshire and parts of Hertfordshire and Buckinghamshire. Surgical service provision includes; general surgery, orthopaedics, trauma care, ear, nose and throat (ENT), oral and maxillofacial, and ophthalmology.

There are nine surgical operating theatres in the main hospital in two separate areas. There are 135 surgical beds across four wards (wards 20, 21, 22, 23) a Surgical Assessment Unit (SAU) and a day case ward.

The number of surgical admissions between January 2015 and December 2015 were 33,047 inpatient admissions of which 5,478 were elective (continuous stay of a patient using a hospital bed), 19,285 were day cases and 8,284 were emergency admissions.

We visited all surgical services as part of this inspection, and spoke with 70 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists and ward managers. We spoke with 16 patients, and examined 14 patient records, including medical and nursing notes.

During our inspection, the day case unit was closed as per the trust refurbishment plans and a newly furnished unit with two new orthopaedic theatres were planned to open to January 2016. The day case unit would provide day case surgery to prevent patients being admitted to the main surgical wards.

## Summary of findings

Overall, we rated surgical services as good for safe, effective, caring, responsive and for being well-led.

There was a culture of incident reporting and staff said they received feedback and learning from serious incidents. However, not all staff always received feedback on clinical incidents. Staff were able to speak openly about issues and serious incidents.

The environment was visibly clean and generally staff followed the trust policy on infection control, although there was variable completion of cleaning schedules available within some of the wards and theatres.

Medical staffing was appropriate and there were good emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.

There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts but this was well managed and patients' needs were met at the time of the inspection.

Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.

# Surgery

Patients outcomes were generally good but not all staff were aware of patients' outcomes relating to national audits or performance measures.

Most staff had received annual appraisals and generally support systems for staff development were effective. Staff had generally completed mandatory training provided by the trust.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures to keep people safe.

The consent process commenced in out-patients and consent was reconfirmed at the time of admission. However, this was not always recorded as the consent form was scanned onto the computer and the confirmation signature could not be added to this electronic form.

Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.

Patient care records were appropriately completed with sufficient detail and kept securely.

The service had an effective complaints system in place and learning was evident.

We saw some patients were delayed in recovery following surgery due to lack of beds on the wards and some patients could wait in recovery for four hours. Drinks and snacks were offered during this time.

There was support for people with a learning disability and reasonable adjustments were made to the service. However information leaflets and consent forms were not available in other languages. An interpreting service was available and used.

Surgical services were well-led. Senior staff were visible on the wards and theatre areas and staff appreciated this support. There was generally a good awareness amongst staff of the trust's values.

## Are surgery services safe?

Good



Overall, we rated the service as good for safe because:

- There was access to appropriate equipment to provide safe care and treatment.
- Staff told us they were encouraged to report any incidents, and serious incidents were discussed at team meetings. Staff were confident in reporting incidents and were aware of the importance of duty of candour.
- Medicines were appropriately managed and stored safely within the service.
- We observed the Five Steps to Safer Surgery checklists being completed and audits between January 2015 to September 2015 showed 98% compliance.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care. Some of this information was displayed at the entrance to the wards and clinical areas.
- There was good knowledge of signs of the deteriorating patient and we saw that patients were appropriately escalated if their condition deteriorated.
- Staff were aware of safeguarding procedures to keep patients safe.
- Medical staffing was appropriate and there was good emergency cover.
- Nursing and medical handovers were well structured within the surgical wards visited.
- The environment was visibly clean and generally staff followed the trust policy on infection control, although there was variable completion of cleaning schedules available within some of the wards and theatres.
- Patients' needs were being met despite there being a number of vacancies for nursing staff in surgery. Safe staffing levels were being achieved by the use of bank and agency staff.
- Staff generally had had the service's mandatory training.

However we also found:

# Surgery

- Some ward areas did not have dedicated cleaning schedules, for both the environment and equipment. Other areas, mainly theatres, had a dedicated scheduled list for cleaning equipment on a regular basis and this was checked daily.
- We saw that training levels for conflict resolution were below the recommended target set by the trust. Future training was planned.

## Incidents

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- There were no never events reported in 2015. Never events are serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- There had been two serious incidents reported between December 2014 and November 2015. One was classed as a slips, trips or falls and one was classed as a surgical/invasive procedure incident through the Strategic Executive Information System (STEIS).
- One serious incident occurred when a patient's artery was caught during surgery and resulted in the patient being admitted to intensive care and returning to theatre for additional surgery. The consultant was not present during this operation and staff could not access him. Lessons learnt included that the consultant must be present in the theatre environment to assist junior staff during operations if required. Staff in theatre were aware of the lessons learnt and we saw minutes of meetings where this had been discussed.
- All serious incidents were analysed at clinical risk and governance meetings to ensure lessons were learnt. Staff within the surgical services told us they were informed of serious incidents and we saw copies of team meeting minutes which showed that incidents in surgical services had been addressed in a timely manner. However, staff told us they did not always receive feedback regarding all incidents they may have submitted.

- Mortality and morbidity meetings took place on a monthly basis and reviewed any deaths that had occurred in the division. Root cause analyses following incidents were discussed, and any lessons to be learnt were shared and distributed to the staff team.

## Duty of Candour

- 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 understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- The ward sisters and theatre managers described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not, and that these process had been followed with regard to two recent serious incidents.

## Safety thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harms including new pressure ulcers, catheter urinary tract infections (C.U.TIs) and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. Some of this information was displayed on the wards, such as number of falls and pressure ulcers.
- All wards had quality boards in each ward office about the quality of the service. This included their safety thermometer results, infection control audits, results of friends and family tests and the number of complaints. For example on ward 20 there was information relating to a comment from a patient about the bin lids being noisy when closed, the staff had ordered quieter closing bin lids to prevent them banging. On ward 23 the infection control audits were displayed that showed 100% compliance with hand hygiene.

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- Staff levels for each shift were also displayed on the entrance to each ward area.
- Between December 2014 and December 2015, there were two falls recorded in the surgical wards, four pressure ulcers and two urinary tract infections. We saw the minutes of the sisters meeting and ward meeting where falls and pressure ulcers had been discussed to raise awareness amongst staff to ensure care plans were updated during handover.
- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention.
- We found a small number of patients that had not been reassessed 24 hours after admission for VTE which was not compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of venous thromboembolism in adults. We brought this to the attention of senior staff.

## Cleanliness, infection control and hygiene

- The wards and theatres were visibly clean although some ward areas required maintenance, such as repair to damaged walls. The trust had plans in place to address these refurbishment issues.
- The ward areas did not have cleaning schedules available for cleaning all the equipment. We saw daily cleaning schedules for commodes, but not defined cleaning schedules for other equipment. Defined cleaning schedules and standards are recommended by the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- Staff told us they cleaned equipment as they used it. We saw 'I'm clean' sticker on equipment that had been cleaned after use, but unsure how long this was left before being used again. Therefore we were not assured that all equipment was cleaned regularly.
- The trust told us that all cleaning schedules for the environment were displayed on the walls of the clinical areas. In the ward areas they were near the main front doors of each ward and in theatres they were displayed within the clinical area.
- Hand hygiene gels were available throughout the wards and theatres. There was access to hand-wash sinks in bays and side rooms on the wards.
- There was awareness amongst staff about infection control and we observed staff washing their hands and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres.
- Personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities.
- We observed that theatre staff wore the appropriate theatre attire, such as theatre blues, hats and masks. Theatre staff did not leave the theatre environment in their theatre attire and all clothing was laundered by the hospital.
- Guidelines on infection control were in use and staff adhered to the trust's infection control policies.
- Instructions and advice on infection control were displayed in the ward entrances for patients and visitors, including performance on preventing and reducing infection.
- All patients received a Methicillin-resistant Staphylococcus Aureus (MRSA) screen for both planned and emergency admission to hospital. This involves taking a swab to test for MRSA being present on patient's skin or in their nose. This followed the national guidelines.
- We saw signage on side rooms indicating when a patient had an infection and the precautions needed. We observed all staff using alcohol hand gel and protective clothing when attending to patients.
- In each ward area, staff had audited their compliance with infection prevention and control measures. Infection control results were red, amber and green (RAG) rated, with red below 85%, amber between 85-94% and green between 95-100%. Between July 2015 to October 2015, wards 20, 21, and 23 scored amber between 85-94% and ward 21 scored a red rating with 77% compliance. Reports were shared with staff at meetings. We saw action plans which included repair to damaged walls, high dusting required and lamination of posters.
- Surgical services had no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) in the last 12 months.
- Surgical services had two cases of Clostridium Difficile (C.Difficile) in the last 12 months. A root cause analysis had been carried out and lessons learnt included reviewing antibiotic usage and staff to send of a stool sample sooner in patients with loose stools.

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- The trust's 2015 Patient Led Assessments of the Care Environment (PLACE) indicators were better than the England average. Cleanliness scored 100% across all areas.
- Surgical site infection data between April 2015 and June 2015 indicated that infection rates for hip replacements were better than the national benchmark. However infection rates following knee replacements were higher than the national benchmark of 1.6% at 9.5% for the same time period. Staff told us action plans had been implemented to reduce surgical site infection rates such as ensuring theatre doors remained closed during the operation and regular wound reviews.

## Environment and equipment

- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was checked daily, and documented as complete and ready for use. The trolleys were secured with tags which were removed daily to check the trolley and contents were in date.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- We saw some sterile equipment stored in the ward sluice, we raised this with the ward sister and the equipment was moved to a sterile environment.
- There were systems to maintain and service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- We saw that hoists and firefighting equipment had been regularly checked and serviced.
- Theatre had dedicated storage rooms for equipment and surgical instruments. These areas were clean and tidy.
- Staff within the recovery unit said they had all the emergency equipment they required at hand. We observed sufficient equipment available during our visit to the recovery unit.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed. Bins were emptied regularly and we observed porters wearing protective clothing when emptying bins.
- Some of the wards were in need of repair, we saw damaged walls in the corridor, a wall panel removed in a

sluice due to the equipment leaking, a worktop in the kitchen that was chipped and walls needed painting due to chips in the paintwork. The ward managers told us that kitchen refurbishing was planned and that other areas within the wards could be painted and this would be raised with the hospital estates department.

## Medicines

- The hospital used an electronic prescribing and medication administration record system which facilitated the safe administration of medicines.
- Medicines were checked and reconciled by pharmacy staff on a weekly basis, and an audit was completed monthly to check stock and utilisation. The reconciliation audit for both medical and surgical wards in October 2015 showed only 50% compliance. We saw a specific action plan that was to be implemented to improve compliance which included prioritising reconciliation, additional support from pharmacy staff and a review of the audit process.
- Some prescription medicines are controlled under the Misuse of Drugs legislation 2001. These medicines are called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. The CD registers on the wards were found to be appropriately completed and checked.
- Medicines within the wards were stored correctly, including in locked cupboards or fridges when necessary.
- We observed nursing staff locking drugs trolleys during the medication round when they administered medicines to patients. Nursing staff wore a red apron to indicate they were administering medicines to alert staff not to disturb them to prevent drug errors.
- We reviewed the prescription and medication charts of six patients on two wards and found records of drug administration were completed correctly. These records were clear and fully completed. Patient's allergies to any medicines were appropriately recorded.
- The temperature of medicine fridges were monitored daily. Medicines requiring refrigeration can be very sensitive to temperature fluctuation and therefore must be maintained between 2°C and 8°C. We saw all areas complied with this as daily temperatures were recorded.

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The room temperatures were also monitored and were within the desired limits of 15°C and 25 °C. Air conditioning units had been put in place to help regulate the room temperatures.

- Stocks of intravenous fluids were stored securely on shelving within cupboards.
- We observed medicines were stored appropriately within the theatres visited.
- There was a small satellite pharmacy unit near the surgical wards to assist with replenishment of medication and direct access for patients to collect their medications to take home to prevent delays in discharge and long waits for medication.
- During the doctor's ward rounds, medication charts were not always reviewed by the medical team as they were electronic and we were told that junior doctors reviewed these after the ward rounds, under the direction of their consultant. We raised this with the trust, who informed us that each surgeon had an agreed amount of ward time in their job plans and senior clinicians reviewed the prescription charts whilst on their ward rounds. All patients had a responsible medical officer who was a consultant and who has overall responsibility for reviewing all aspects of patient treatment and care, which included medication.

## Records

- The hospital had an electronic patient record system where previous records were stored on the computer and current records were hard paper copy.
- We examined 14 patients' medical and nursing records across surgical wards and theatres. These were detailed and included comprehensive pre-assessments.
- The records we reviewed showed that the Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was completed for all patients.
- Medical records were stored securely in trolleys behind the nurse's station; nursing notes were stored at the patient's bedside.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- During nursing handover the nursing records were reviewed by the ward sister to ensure all risk assessments had been completed and were up to date.

## Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The surgical teams were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- The trust reported in October 2015, 84% of staff in surgery had up to date training in Adult Safeguarding and 89% had up to date training in Safeguarding Children at levels 1 and 2. This met the trust's target of 80%.

## Mandatory training

- Staff told us that in most cases they were on target with their mandatory training. However, due to vacancies, some staff still required training. There were further training dates planned in the future.
- The electronic rostering system recorded training completed by each staff member and the dates required for renewal. This was used to assist with planning staff training.
- The trust's training records showed that 88% of medical and nursing staff in the surgical division had completed their mandatory training in all modules except for conflict resolution which was only at 51% against a trust target of 80%.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.

## Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained.
- Patients for elective surgery attended a preoperative assessment clinic where all required tests were undertaken. For example, MRSA screening and any blood tests. If required, patients were able to be reviewed by an anaesthetist.

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- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- We spoke with staff in the anaesthetic and recovery areas, and found that they were competent in recognising deteriorating patients. The national early warning score (NEWS) was used and staff had attended training. NEWS charts were used to identify if a patient is deteriorating. In accordance with the trust's deteriorating patient policy, staff used the NEWS charts to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these. We reviewed 14 patient notes and found NEWS charts were being used to record patients' vital signs.
- The national early warning system (NEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with NICE clinical guidance CG50.
- Staff had access to the trust's critical care and outreach team for patients that had deteriorated or required additional medical input. Staff told us they were very supportive to staff on the ward and visited the patients on the wards as required.
- We were shown the audit results for the Five Steps to Safer Surgery checklist between January 2015 and September 2015 which confirmed 98% compliance with this procedure. The theatre team had relaunched this form and process to increase staff engagement and ensure that staff were participating in this process and the documentation and information collected was correct. Both medical and nursing staff were positive about the relaunch to improve staff engagement.
- We looked at the checklists which had been completed, which included, for example, the patient's identity and whether they had any known allergies.
- We observed a patient being admitted prior to surgery. The consultant had checked with the patient which side the operation was to take place and they confirmed this with the notes. The patient was marked on that side to make sure the correct side was operated on during their surgery.
- There was 24 hour access to emergency surgery teams, including theatres, doctors and endoscopy.

## Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited. Staffing levels were appropriate to meet patients' needs during our inspection. Actual staffing levels met planned staffing levels in the areas we visited.
- The trust performed biannual staffing reviews for all wards including surgical wards, which included benchmarking with four neighbouring trusts and professional judgement to identify the appropriate workforce to allocate nursing numbers.
- A daily allocation meeting took place to review staffing numbers, skill mix and patients acuity. Decisions were then made to deploy staff to different wards to ensure patient safety. Future planning of staffing levels and patients' requirements were also discussed.
- Vacancies rates were 16% in October 2015, and vacant shifts were filled with bank and agency staff. The ward sisters told us that some staff picked up additional shifts to support the wards. The sister told us they requested the same agency staff to ensure continuity within the wards. This was confirmed by agency staff spoken too.
- Long term agency staff were being used and staff blocked booked for shifts ahead to assist with safe staffing levels and continuity of care.
- We saw completed induction checklists in place for bank and agency staff within the surgical wards and theatre areas. This ensured staff were orientated to the ward and aware of where equipment was stored and how to access information. However, on some occasions ward staff had not always checked there were up to date each shift in line with their responsibilities. We raised that with senior nurses during the inspection.
- Staff in both surgical wards and theatre said they recognised recruitment as a major safety risk to the service. This was captured on the risk register.
- The management team told us of various measures they had undertaken, such as overseas recruitment initiatives. Staff were aware of these initiatives and were supportive of them. To support retention, some staff were offered development opportunities and leadership courses.
- Nursing handovers occurred at the change of shift. We observed three handovers on three wards (wards 20, 21

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and 23). The handovers occurred in the ward office for all staff and patient privacy, dignity and confidentiality were maintained. Staff were then allocated to bays and a more detailed handover took place at the patient's bedside, when staff introduced themselves to patients and involved the patients in discussion. The ward sister reviewed the nursing notes to ensure all assessment and care plans were up to date.

- The handovers were well structured and used electronic information sheets. The information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments.

## Surgical staffing

- Records provided by the trust showed that the medical staffing levels were similar to the national average, with 41% for consultant cover which is the same as the England average. Middle career group (doctors who had been at least three years as a senior house officer or a higher grade within their chosen speciality) was at 19% which was higher than the England average of 11%. Registrars were 27% which was lower than the England average of 37%, whereas junior doctors were 13% which was slightly higher than the national England average of 12%. Doctors and consultants said they had sufficient cover for their specialities. Staffing levels were appropriate to meet patients' needs during our inspection.
- In October 2015, vacancy rates for medical positions within the surgical division was 19%. Locum doctors were sometimes used and some posts had been filled and waiting for candidates to commence their roles. We spoke with one locum doctor who had worked at the hospital several times over the last few months and she had an induction and felt supported by her colleagues.
- Junior doctors had specific personal development plans, a mentor and clinical support. They told us they felt supported and the consultants were accessible, approachable and available when required.
- Doctors ward rounds occurred daily and involved nursing and allied professionals, such as physiotherapists.
- We observed doctors' surgical ward rounds on ward 21 and the Surgical Assessment Unit (SAU) which were well

organised and structured. There was good interaction between doctors and nursing staff. Nursing staff were encouraged to be part of the doctors ward rounds to ensure ongoing care was planned and agreed.

- Surgical consultants worked weekends and carried out ward rounds to ensure that there was provision of consultant led care and decision making. There was consultant cover for emergencies 24 hours a day.
- There was a trauma and orthopaedic consultant on call seven days a week to be available for any emergencies. There was a dedicated orthogeriatrician to support patients with a fractured neck of femur. Orthogeriatricians aimed to visit patients on the ward on the day of admission to assist with care planning.

## Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services.
- Staff knowledge regarding major incidents was limited within the surgical areas with some staff uncertain as to what constituted a major incident. Staff told us they would refer to the online policy and call senior staff if this occurred. Staff were aware of fire safety protocols.

## Are surgery services effective?

Good



Overall we rated the service as good for effective:

- Patients generally had good outcomes and received effective care and treatment based on national guidance that met their needs.
- Performance and outcomes generally met trust and national targets in most areas.
- The trust participated in national and local audits, for example the Patient Reported Outcome Measures (PROMS) which overall showed the trust was matching results seen nationally in PROMS measures for hips and knees, groin and varicose vein surgery. The national Hip Fracture database audit showed the trust performed better than the England average in three of the seven measures.
- Policies and procedures were accessible, and staff were aware of the relevant information. Care was monitored to demonstrate compliance with standards.

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- Patient's pain, nutrition and hydration was appropriately managed.
- The surgical service had a consultant-led, seven day service, with elective lists in all theatres one Saturday per month.
- Two separate general surgeons were on call to meet patient specific needs. One that specialised in upper surgical conditions and one that specialised in lower surgical conditions.
- Generally, staff had awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

However, we also found:

- Data from the Bowel Cancer Audit 2015 showed that several results for the trust were not available due to data not being submitted.
- Patients were asked for their consent to procedures appropriately and correctly. However when patients were admitted for surgery and confirmation of consent was sought this could not be documented on the consent form as it had been scanned into the hospitals electronic patient's records.
- Not all patients had been reassessed 24 hours after admission for VTE which was not compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of venous thromboembolism in adults.

## Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health and social care needs (clinical needs, mental health, physical health, and nutrition and hydration needs). Patient's care and treatment was planned and delivered in line with evidence based guidelines for example nutritional and hydration needs, falls assessment and infection control guidance.
- Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. The trust performed

better than the England average in eight out of the nine measures. The trust had improved in every indicator from 2014 to 2015. The hospital had a dedicated nurse to review the care of patients with fractured hips. There was a resource folder and information displayed on ward 23 with information about the care, and audit process to raise staff awareness and compliance.

- Venous thromboembolism (VTE) assessments were recorded on the electronic drug charts and were clear and evidence-based, ensuring best practice in assessment and prevention.
- 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.

## Pain relief

- Pain was generally assessed and managed effectively.
- Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner. Pain management for individual patients was discussed at handovers as required.
- Monthly pain management audits showed an average of 98% compliance between December 2014 and October 2015. Audits included documentation of pain, administration of pain relief, had pain score been reassessed following administration of pain relief and documented evidence that effective pain management had been planned. We saw action plans in place to improve pain management which included, additional training, the pain nurse visiting wards more often and a review of the assessment process.
- A nurse specialist in pain control was contactable by telephone for advice and would assess patients.
- Patients confirmed that they had received their medication and pain relief in a timely manner.

## Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition.
- If a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician.
- Monthly nutrition audits were carried out and showed an average of 92% compliance between December 2014 and October 2015. Audit included whether the patient's

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Body Mass Index (BMI) been documented within 24 hours of admission and had the patient's nutritional risk (MUST score) recorded within 24 hours of admission to the ward.

- In all 14 records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietician.
- Depending on the type of surgery they were undergoing, some patients for elective procedures were given a pre-operative drink. The purpose of this drink was to aid the patient's recovery following their operation.

## Patient outcomes

- Mortality and morbidity meetings occurred monthly across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The trust had an action plan to improve the mortality and morbidity rates. The data was monitored by the divisional team and reported to the trust board.
- Historically mortality following fracture neck of femur was higher in the trust in 2013 at 13% and 2014 at 8% compared to the national average of 7%. The trust implemented a specific action plan to reduce the mortality. Staff were aware of the actions taken which included a named orthogeriatrician for each patient, a dedicated fracture neck of femur ward and a new integrated care pathway. The recent data for 2015 showed an improvement at 6%.
- The Hip Fracture Audit in 2015 showed the trust performed better than the England average for eight out of nine applicable measures. They performed worse for patients admitted to an orthopaedic ward within 4 hours (27.8% compared to the England average of 46.1%). The trust improved in every indicator in 2015 compared to 2014.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme, and the National Joint Registry (NJR). Overall, the trust was matching results seen nationally in PROMS measures for hips, knees, varicose veins and groin hernia which measure patient's outcomes of health following surgery.
- The trust was aligned with the improvement seen nationally in PROMS and had a lower proportion of patients worsening than the national average. The

results indicated that the trust had improved the scores compared with the national average. This is a measure of general health rather than specifically related to outcome following surgery.

- In May 2015, there was an elevated risk for composite of hip related PROMS indicators. The hospital management told us that the consultants had reviewed each case individually and would ensure more discussions with patients on their expected outcomes.
- The relative risk of readmission for both elective and non-elective admissions were higher than the England average between June 2014 and May 2015. The latest data from the trust showed that between June and December 2015, 5% of elective surgical patients were readmitted and 12% of emergency patients were readmitted.
- Data from the Bowel Cancer Audit 2015 showed that several results for the trust were not available due to data not being submitted. The risk-adjusted 18-month stoma rate in rectal cancer patients undergoing major resection was 58% which was worse than the England average of 50%. The trust told us that the service had made significant progress in data collection for the 2015 data (to be reported in 2016) through:
  - Implementing a revised outcome proforma that included additional data requirements relating to pre and post-surgery performance data;
  - Improvements in the data collection and uploading onto the trust's electronic systems and data revalidation processes;
  - Consultants had been trained and were now responsible for the uploading of the clinical information for their respective patients.
- In relation to the stoma rate, the trust said the rate of 58% was well within the 95% limits (as per the Bowel Cancer Audit 2015 requirements) and was not therefore identified as an outlier in this area.
- Data from the National Emergency Laparotomy Audit 2015 showed the trust had a mixed performance. More than 70% of patients arrived in theatres appropriate to the urgency of the procedure and had a consultant present in theatre. Less than 50% of patients had a consultant review within 12 hours of emergency admission, had risks documented preoperatively, had a preoperative review by a consultant and anaesthetist and assessment by a Medical Consultant for the care of

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older people specialist in patients over 70 years'. The trust had an action plan in place dated November 2015 to address these concerns and actions included the introduction of twice daily consultant led ward rounds.

- Data from the Lung Cancer Audit 2015 showed that 100% of patients were discussed at a multidisciplinary team meeting which was better than the England average of 93.6%, however only 3.4% of patients received surgery compared to the England average of 15.4%.
- Patients considered their outcomes as being good. One patient said the "it was the best care and treatment they had ever had and they had been in a lot of hospitals". Another said they "could not fault the care".

## Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a specific induction programme for all staff. Staff that had attended the induction programme told us this was useful. The induction programme included orientation to the wards, specific training such as fire safety, infection control and manual handling as well as awareness of policies.
- Nursing staff (both agency and permanent) felt well supported and adequately trained in their local areas.
- Junior doctors within surgery all reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Trust data for January 2016 showed that within surgery, 86% of staff had received their appraisals against a target of 90%. Some staff told us they had appraisals booked in the near future.
- Staff told us there was training opportunities for personal development and to enhance their skills such as cannulation, catheterisation, intravenous therapy and first assistant (assisting surgeons during theatres).
- Many of the band 6 and 7 nurses were attending a local leadership programme which they felt improved their skills in managing staff and gave opportunities for personal development and career progression.
- The trust was on target to achieve revalidation of all medical staff within timescales set by the General Medical Council. For example, 80 out of 83 consultants had been revalidated at the time of the inspection.

## Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors and physiotherapists.
- There was good multidisciplinary working within the wards to ensure patient care was coordinated and the staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards then liaising with and updating the nursing and medical staff.
- Staff said that they could access medical staff when needed, to support patients' medical needs. We saw one family who had been informed that their relative was for palliative care having a meeting with the consultants, junior doctors and ward sister to discuss the options and ongoing care of their relative. This meeting was held in a private room. The patient was referred to the palliative care team and we saw they attended the ward promptly and spent time with the medical and nursing team to discuss care options.
- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported and that their contribution to overall patient care was valued.
- Staff could access the learning disability lead, critical care team, pain management team, social workers and safeguarding teams who were able to provide advice and support to the surgical teams.
- We observed the theatre staff working well together as a team, discussing patients' needs, equipment required and planning for the theatre lists.
- When patients were waiting for several hours in recovery due to lack of beds, we saw good communication between wards and theatres and they escalated the issues to the senior management. The senior management and matron reviewed all surgical wards areas and were able to transfer patients back to the wards quickly to prevent further delays.

## Seven-day services

- Patients had access to consultant cover seven days per week and other support services, such as pharmacy, physiotherapy, occupational therapy and theatres were available if required.

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- Consultants carried out daily ward rounds including the weekends on all surgical wards.
- Two separate general surgeons were on call to meet patient specific needs. One that specialised in upper surgical conditions and one that specialised in lower surgical conditions.
- Emergency theatres were available seven days a week and additional staff were on call, if extra staff were needed to manage emergencies.
- Physiotherapists were available at weekends; they would visit each surgical ward to offer support.
- Staff told us they had access to imaging, pathology and endoscopy out of hours. Pharmacy also provided an out of hour's service and they were open at weekends.
- Theatres had a 'Super Saturday' once a month when all theatres carried out elective lists all day to help with waiting lists. This was seen as positive by all staff

## Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff said they had good access to patient related information and records whenever required.
- Patient's previous admissions were held electronically and current episodes in paper form and were scanned onto the computer following discharge. Staff were able to access previous records on the computers.
- Staff said that when a patient was transferred from the emergency department (ED) to a ward, they had access to 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.
- Discharge summaries to GPs were electronic and the patient was given a paper copy.
- We observed on-going care information was shared appropriately at handovers.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood consent, decision making requirements and guidance. The trust 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, one for children and another for procedures not under a general anaesthetic.

- All consent forms we saw were for patients who were able to consent to their operation/procedure and they were completed in full (they contained details of the operation/procedure and any risks associated with this). Patients were also able to have a copy if they wanted.
- There were no consent forms available in other languages. Interpreter services were available.
- The consent process generally occurred in outpatients clinics. Patients were asked for their consent to procedures appropriately and correctly. However when patients were admitted for surgery and confirmation of consent was sought this could not be documented on the consent form as it had been scanned into the hospital's electronic patient's records. This does not comply with the Department of Health guidance 2001 on Good practice in consent. A separate form was available, but this was not always completed. We raised this with senior management who advised they would review the policy and process for consent. The Clinical Operational Board in January 2016 formally agreed a working group to review consent.
- A consent audit carried out in November 2015 showed results for the surgical division was 60% compliance. A specific action plan was in place to review the consent policy, which included, reviewing consent forms and tools, producing a briefing paper on key reminders to improve documentation on consent forms and spot checks by managers to review compliance with the policy.
- Staff told us they had annual training for Mental Capacity Act and Deprivation of Liberty safeguards (DoLS). The overall compliance for the trust was 63%.
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- We saw one DoLS in place which was completed correctly and the patient's family had been informed and were involved in the patient's care.

## Are surgery services caring?

# Surgery

Good



Overall, we rated the service as good for caring.

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- The staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- Surgical and nursing staff kept patients up to date with their condition and how they were progressing.
- Information about their surgery was shared with patients, and patients were able to ask questions.
- Patients and most relatives said they were kept informed and felt involved in the treatment received.
- We observed good emotional support to a family on ward 21.

However, we also found that:

- The service's Friends and Family Test response rates were below the national average but 94% of patients that did respond would recommend the hospital to family and friends.

## Compassionate care

- We saw that patients were treated with dignity, respect and compassion when they were receiving care and support from staff.
- Patients felt supported and well-cared. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them. Staff spent time talking to people, or those close to them.
- Staff generally respected people's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.

- Confidentiality was generally respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication
- We saw results of the Friends and Family Test displayed in the ward office. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. We saw posters encouraging patients to give feedback, so the trust could improve the care provided.
- We saw that the response rate varied across the service. The response rate for friends and family test in surgical wards was below the national average of 36% with a response rate of 22% between December 2014 and November 2015. 94% of patients that did respond would recommend the hospital to family and friends.
- On all surgical wards and in theatre we observed patients having their observations taken for example, blood pressure, temperature and respiratory rate, with care and dignity.
- We saw that nursing staff introduced themselves appropriately and knocked on the door of side rooms before entering.
- We received positive comments from the vast majority of patients we spoke with about their care. Examples of their comments included "If I need help, I get it and its fantastic", "I'd give a gold for care", and "staff are very kind and understanding".

## Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Patient records had individualised care plans, which involved the patient in their planning. One patient told us she was booked as a day case, but was able to stay overnight due to her medical condition and lack of support at home.

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- Two relatives that told us communication was not good and one had to travel a long distance to meet staff on the ward as he could not speak to the relevant person on the phone. We raised this with the ward sister, who immediately met with the relative.

## Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Staff carried out daily quality checks at handovers to ensure care plans were up to date and patients' needs had been assessed including emotional and mental health needs.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- On ward 21, we observed a family being offered emotional support and privacy with a patient who was for palliative care. The medical and nursing staff spent time with the family in a private room and offered drinks.
- The Chaplaincy Service provided a 24 hour service with a full time Lead Chaplain, supported by part time and bank chaplains from other faiths.

## Are surgery services responsive?

Good



Overall we rated the service as good for responsive.

- Service planning generally met the needs of the local people and the community.
- The service regularly carried out operations on a Saturday to meet local need.
- The admitted referral to treatment time (RTT) was consistently above the national standard of 90%, in all specialities apart from trauma and orthopaedic which was at 82%.
- Surgical care and treatment for patient having a fractured neck of femur was comparable to the national average.

- Cancellations of operations were similar to the national average.
- Generally, complaints systems were effective.
- Access and discharge arrangements were effective.
- The average length of stay for patients' in the service was lower than the national average.
- There was support for people with a learning disability, and reasonable adjustments were made to the service provided.
- Arrangements were in place to support patients living with a dementia.

However we also found:

- Bed occupancy levels in the surgical division were high, and the lack of available beds was resulting in patients spending longer periods in the theatre recovery areas.
- Not all information leaflets and consent forms were available in other languages. An interpreting service was available and used.

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

- The service generally understood the different needs of the people it served and acted on these to plan, design and deliver services.
- The service generally planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible, in line with their preferences, and wherever possible provided accommodation that was gender specific, and ensuring the environment and facilities were appropriate and required levels of equipment were available promptly.
- The trust provided monthly report on quantitative and qualitative data to the local Clinical Commissioning Group and had effective relationships with all stakeholders.
- Luton hospital is a regional centre for bariatric surgery and future plans included to develop bariatric services to a wider catchment and develop a wider range of specialist ophthalmology surgery
- The service monitored the use of its theatres to ensure that they were responsive to the needs of patients. The average theatre utilisation during 2015 was 73%.
- To meet the needs of local people, theatres were opened once a month on a Saturday for elective cases.

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- During our inspection the day case unit was closed and a newly furnished unit with a new modular theatre was planned to open in January 2016. This was a planned closure and not due to the inspection.
- The day case unit would provide day case surgery to prevent patients being admitted to the main surgical wards.
- We saw plans for a new theatre complex which included additional theatres and a specific admission area. These plans were awaiting funding approval.
- A new orthopaedic hub opened in November 2015 and was situated a short distance from the main site. The new build was planned to address the large number of patients attending the department. The facilities included an increased number of clinic rooms, x-ray and plastering facilities and physiotherapy rooms.

## Access and flow

- Between December 2014 and November 2015, the percentage of patients waiting less than 18 weeks from referral to treatment time (RTT) was consistently 92%, which met the national average of 90%, in all specialities apart from trauma and orthopaedic which was at 82%. RTT monitors the length of time from referral through to elective treatment. These targets are no longer collated and were stopped by the NHS in June 2015.
- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. In 2015, 75% of patients with a fractured neck of femur had surgery within 24 hours of admission, which was the same as the national average. The length of stay in hospital was 14 days, which was better than the national average.
- Between October 2014 and September 2015, 286 patients had their operations cancelled and seven were not rebooked within 28 days. This was in line with the England average.
- The average length of patient stay for both elective and non-elective patients was lower than the England average for July 2014 to June 2015. For all elective Luton and Dunstable was 2.2 days compared to 3.3 for the England national average and for non-elective surgery it was 3.7 days compared to the England average of 5.2.
- Some surgical patients remained in recovery for four to five hours due to lack of beds in the surgical wards. During the inspection there were eight patients delayed going back to wards due to bed pressures. We saw patients were offered drinks and snacks during this time and their individual care needs were met. Some patients were discharged home directly from recovery and ward nurses attended to the patients to ensure they had the correct discharge information.
- In the last twelve months, on one occasion four elective surgical patients stayed in recovery overnight due to severe bed pressures. Patients were transferred the following morning to surgical wards. The patients were looked after by ward nurses and catering facilities were provided, as part of the service's contingency plan.
- During our inspection additional beds were opened on ward 19a due to bed pressures. We found the ward was adequately staffed with the day case staff. The ward was fully functioning with medication, catering facilities and support services.
- The hospital had a nurse led pre-operative assessment clinic. Most patients had a pre-operative assessment, which included for example, testing for MRSA.
- The consultant and anaesthetist saw patients prior to their operation in the admissions area which was separate to the theatres and wards. All patients arrived at the same time and could wait four or five hours in the waiting area as the hospital did not have staggered admission times. Patients were escorted up to the theatre by the admission staff. There were plans to include a new admission area in the new theatre complex and staggered admission would be reviewed at this time.
- Patients were kept up to date on waiting times and patients waiting for long periods were offered water if appropriate.
- Some patients were discharged directly from the recovery and we saw staff from the day case unit discussing discharge arrangements with the staff and patients. The patients were given a copy of the discharge letter that was sent to the GP and relevant information leaflets, such as post-operative care.
- The surgical assessment unit had a seated waiting area and treatment room, where patients could be seen by the doctors and treatment offered or arranged for another date to prevent admission direct to the ward.
- There were a small number of surgical patients on non-surgical wards and the surgical doctors would visit the patients daily. Processes were in place to ensure these surgical outlying patients were appropriately placed on other wards, and that their needs were being met.

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## Meeting people's individual needs

- Services were generally planned to take into account the individual needs of patients.
- Patients who attended the pre-operative assessment clinic were given information leaflets such as; you and your anaesthetic, preventing thrombosis, and fasting instructions. However, these information leaflets were not available in other languages.
- Patients were also offered advice on smoking cessation, alcohol intake and dietary advice if required during the preoperative assessment.
- Staff told us that documents could be translated upon request and letters to individual patients detailing clinical care, treatment and results could also be translated. We saw some leaflets in other languages such as 'Welcome to the hospital'.
- Staff told us they had access to translation services in person or via the telephone system.
- Staff and patients reported they did not have mixed gender bays on surgical wards.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- Staff told us that people with a learning disability or anxiety were encouraged to visit the hospital, so they could become comfortable with the process. People with a learning disability were given longer surgical preoperative assessment appointments, which took into account their needs.
- An electronic discharge summary was sent to a patient's GP upon a patient's discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication. The patients were given a paper copy.
- Ward staff told us they had link nurses for specific areas, for example, learning disability and infection control. The link nurses were able to support staff and share information.
- We tracked a patient's journey from the admissions to theatre. We saw good interaction between the admissions staff and theatre staff which included the handover of patient's notes. The patients were escorted at all times in the theatre environment.

- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required. The care support staff assisted patients with menu choices and ensured dietary needs were met.
- Staff were available to help serve food and assist those patients who needed help. We observed good interaction between staff and patients to encourage patients to eat their meals.
- We observed there were 'red trays' to identify patients who needed help with eating and drinking, including when patients were at risk of malnutrition or dehydration.
- There were additional drinks, snacks and yoghurts available on the wards.
- When patients were in recovery for long periods, snacks and drinks were provided.

## Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- Literature and posters were also displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- The trust reported 215 complaints within surgery in 2015. Most related to poor communication, issues with the admission process and discharge process, delays in treatment and some aspects of care. The average timeframe to process closed complaints was 36 days which was not in line with the trust's policy of 25 days. People were kept informed of the progress of their complaint. We saw actions taken in response to complaints such as additional staff employed to assist with increased activity and to prevent further delays in care and additional theatre activity to reduce waiting times.
- None of the patients we spoke with had any complaints; several patients said they were aware of how to complain if they needed to.

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- The ward sisters received all the complaints relevant to their service and gave feedback to staff at ward team meetings regarding complaints in which they were involved.
- Staff told us that some verbal complaints were managed on the wards or in theatres, and were not always reported. Staff told us these complaints were dealt with as soon as they occurred by either the ward sister or matron. This meant that complaints were concluded at service level with no outcomes, themes or lessons learnt being cascaded to staff.
- Written complaints were managed by the matron and at directorate level. A full investigation was carried out and a written response provided to patients. Outcomes, lessons learnt and actions were not always fully cascaded to the staff within the wards or theatres some staff said.

## Are surgery services well-led?

Good



Overall, we rated the service as good for well-led.

- The senior surgical management team had a clear vision in place to deliver good quality services and care to patients. The surgical directorate and division had a long term strategy in place with clear objectives.
- The service had regular divisional board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. Matrons and ward sisters also had meetings to discuss quality indicators, such as staffing levels, patients' safety concerns and bed occupancy.
- We saw strong leadership, commitment and support from the senior team within the surgical division.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services.
- Staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings.
- The culture of learning from incidents was promoted amongst staff, and they told us they were encouraged to report incidents.

- A number of staff we spoke with had been working at the trust for over 10 years and said it was a good place to work.

However we also found:

- Most staff we spoke with were unaware of the national audits, such as PROMs and hip fractures database undertaken by the trust and information on outcomes was not shared with all staff groups.
- Not all staff we spoke with were aware of the trust's values.

## Vision and strategy for this service

- We saw the trust's values on display within the ward which included "The Luton and Dunstable hospital is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available and with kindness and understanding from all our staff". Not all staff we spoke with were aware of the trust's values.
- We saw the surgical strategic plan for 2014 to 2019 which included a six day elective programme for theatres which had been implemented. Future plans included to develop bariatric services to a wider catchment and develop a wider range of specialist ophthalmology surgery. Areas of the strategic plans were discussed at the monthly surgical board meetings.
- Surgical services were developing to improve responses to increased demand, which included increasing theatre use, by using one Saturday a month and opening additional beds to meet demands.
- We saw plans for a new theatre complex which included additional theatres, storage space and admission areas for patients. The plans were waiting confirmation of funding. Staff in theatres were aware of the strategic plans.

## Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks and to inform the executive board of key risk and performance issues.
- Clinical leaders in the division told us they had oversight of all incidents and met with matrons and ward sisters to discuss these. We saw minutes of these meetings where incidents and complaints were discussed and some lessons learned, such the implementation of a

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satellite pharmacy department to reduce waiting times for medication to take home and the need to improve discharge information. Ward sisters discussed incidents and complaints at ward team meetings.

- The service had regular divisional board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed.
- Matrons and ward sisters also had daily meetings to discuss staffing levels, patients' safety concerns and bed occupancy.
- Staff said they received information regarding serious incidents but did not receive feedback on all incidents they had raised.
- The trust had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and nutritional needs was monitored and acted upon in line with the trust's policy and national standards.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register where they were regularly reviewed. The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. The risk register was discussed at the surgical clinical risk and governance meetings.

## Leadership of service

- Leadership within the surgical division reflected the visions and values of the trust and service to promote good quality care.
- We saw strong leadership, commitment and support from the senior team within the surgical division. The senior staff were responsive, accessible and available to support staff during challenging situations such as the backlog of patients in recovery and the need to open additional beds.
- Junior surgical doctors reported consultant surgeons to be supportive and encouraging. Junior doctors told us they felt well supervised by consultants.

- Junior staff on the surgical wards and within theatres said they were aware of the chief executive officer (CEO) and the chief nurse and that on occasions they had visited the wards and theatres.
- Each ward had a ward sister, supported by a surgical a matron who provided day-to-day leadership to members of staff on the ward.
- The gynaecology matron was supporting the surgical division until the surgical matron commenced in post in February 2016. We saw the matron on the wards daily and ward staff said that she was a good support and offered help and advice.
- The junior nursing staff on all wards were unanimous in stating that their immediate nursing support was good, and there was clear leadership from ward sisters, matron, and the chief nurse.
- Staff within the surgical division said they were well supported by their managers who they felt would look after their welfare.
- We observed the theatres were well managed with good leadership. We saw all staff working as a team with defined roles to ensure the safe care of a patient entering theatre.
- There was general agreement from management and staff in the wards and theatres that recruitment and retention of nursing staff was seen as a priority by the trust.
- The day surgery unit was planned to open in January 2016. Staff told us they were involved in the design and layout of the building.

## Culture within the service

- Staff were enthusiastic about working for the trust and how they were treated by them as a whole. They also felt respected and valued.
- We spoke with a number of staff who had worked for the trust for over 10 years and all said they felt part of the team and enjoyed working at the hospital.
- Staff we spoke with worked well together as a team, and said they were proud to work for the trust.
- Across all wards and theatres staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Most staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings, development for theatres and the day case unit.

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- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.

## Public engagement

- The national in-patient survey from 2014 showed positive feedback in many areas such as patients' experience. We saw a specific action plan for areas of improvement which included improving verbal and written communication between teams and improving information provided on discharge. This action plan was ongoing and updated at the divisional meeting in October 2015.

## Staff engagement

- Staff were encouraged to share their views at their team meetings.
- The trust held recent staff engagement groups to promote the hospital values and informed staff of future plans. Staff that attended said they felt involved and valued at these meetings.

- We saw the trust newsletter which was distributed throughout the hospital to update staff on current issues and future plans.
- The NHS staff survey from 2014 showed positive feedback for effective workforce and staff involved in developments, training and appraisals. Negative results related to staff experience of physical violence from patients, relatives, visitors and other staff and hours of working.

## Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors and trainee staff in theatres were involved in audits and the results shared within the department.
- Super Saturday was implemented for elective surgery to help reduce waiting lists.
- The new day case unit and modular theatre was due to open in January 2016, to prevent day case patients being admitted to the surgical wards.
- There were future plans to extend the theatre complex and include an admissions area; these were waiting funding and final approval.

# Critical care

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

## Information about the service

Critical care services are provided by two separate units within Luton and Dunstable Hospital NHS Foundation Trust. An intensive therapy unit (ITU) and a high dependency unit (HDU). The ITU had seven beds and provided care for six (level three) ITU patients plus a bed which was used mainly for patients following major elective surgery. The HDU had 15 physical beds and provided (level two) HDU care, including respiratory HDU. Level two beds are for patients who need higher levels of care and more detailed observation than provided on general wards. These patients may have a single failing organ system or require postoperative care. Level three beds are for ITU patients including those who need advanced respiratory support, or complex support for multi-organ failure. The ITU received approximately 420 patients and HDU 750 patients per year (2015).

Critical care services also provided a Critical Care Outreach (CCO) team, which supported patients at risk of clinical deterioration on the wards of the hospital.

During our inspection, the team spoke with 25 members of staff including consultants, trainee doctors, different grades of nurses, allied health professionals, care support workers and those in service support roles. We also spoke with patients and their visiting relatives and friends.

We checked the clinical environment, observed ward rounds, nursing and medical staff handovers and assessed patients' health care records.

We carried out an unannounced inspection on the 27 January 2016 and the HDU was found to have undergone urgent reconfiguration, including reducing the number of available beds available to 11.

# Critical care

## Summary of findings

Overall, we rated the critical care service as requires improvement.

We found that safe and well-led areas required improvement. However, we rated critical care services good for effective, caring and responsive.

We found areas that required improvement, particularly on the high dependency unit (HDU). Medicines were not being safely prescribed and administered on HDU. For example, high risk medicines administered when the prescription was not signed by the prescriber.

The level of nurse to patient ratio on HDU did not meet core standards for critical care services (Guidelines for the provision of intensive care services (GPICS) 2015) on the initial inspection.

The HDU environment was found to be non-compliant with Department of Health 2013 best practice guidelines for critical care facilities (Health Building Note HBN 04-02) regarding size of bed spaces and provision of hand washing facilities. However, in response to concerns we raised at the time of the inspection, the HDU had undergone urgent reconfiguration and action had been taken to reduce the number of beds available to 11, while keeping the staffing the same. Following the reconfiguration, we returned during an unannounced inspection and found that the nurse staffing levels met core standards for critical care services (GPICS 2015), there were larger sized bed spaces and medicines were being safely prescribed and administered.

There was also a low number of low or no harm incidents reported by critical care services and a good track record related to incidence of infection.

Critical care services were effective. The trust complied with the recommendations within guidance from the National Institute for Health and Care Excellence (NICE guideline 50) for acutely ill patients in hospital.

Patients' pain scores were being recorded and appropriate pain relief was being provided. Care bundles (evidenced based procedures) were in place for the use of ventilators and central lines (a central venous access device which is a long thin tube inserted into a vein in the chest).

The ITU contributed to the Intensive Care National Audit and Research Centre (ICNARC) database and the mortality ratio for the unit was within statistically acceptable limits.

A practice development nurse supported both units with competency completion and induction of new nursing staff.

Patients in the units were required to be screened for delirium using a recognised screening tool (CAM-ICU). However, none of the patients on HDU had been scored for delirium (National Institute for Health and Care Excellence NICE CG83). We raised this with the trust at the time of inspection. All patients had been appropriately assessed when we returned for the unannounced inspection.

HDU did not contribute to the ICNARC database, which meant outcomes were not being benchmarked against similar services. They were unable to meet NICE guidance for rehabilitation of the critically ill patients due to further resources required to increase physiotherapy and follow up clinic provision.

Critical care services were caring. People using the service, including patients and their families were positive about the care and treatment they had received on the critical care units. Staff involved the patients as much as possible in decision making and kept them informed about progress with treatment.

Overall critical care services were responsive to patient's needs. There was provision of facilities for visitors to the ITU, including a waiting room, hot and cold drinks, toilet facilities and a private room, which could be used for discussions.

ITU performed within expected levels for delayed discharges and transferring patients from ITU to a ward overnight when compared with similar units in the ICNARC audit (2014/2015). However, HDU transferred on average 24% of patients to a ward overnight per month (six month period ending December 2015).

At a unit level there was acknowledgement and reporting of mixed sex occupancy. The trust policy was based on a local agreement with the clinical commissioning group which stated in the majority of cases it may be clinically justified for the patient to

# Critical care

remain within the HDU environment if the speciality bed was unavailable to ensure their safety and quality of care. However, the official number of reported breaches for critical care was nil (between April 2014 and December 2015).

Translation services were not always accessed for patients who needed them. We found that staff used patients' relatives to translate for staff on HDU.

Critical care services were led by a matron and a clinical lead consultant. The challenges and risks regarding HDU were understood by the leaders. However, actions had not been taken to address these prior to inspection. One of the actions taken, after we raised concerns, was to refocus the leadership for HDU, with the matron taking a senior nurse role until improvements were firmly embedded. The ITU and HDU were not operating as integrated services and had separate rotas, study days, charts and operational policies. There was also a lack of knowledge of the vision for the services demonstrated by staff.

Critical care services had a risk register where risks were documented, reviewed and updated. We also saw evidence of critical care delivery group and directorate meetings being held. Within the minutes of these meetings, we saw incident reporting, staffing, performance indicators being discussed.

## Are critical care services safe?

Requires improvement



Overall, we rated the service as requiring improvement for safety because:

- During our initial inspection, the HDU environment was not found to meet recommendations regarding size of bed spaces and provision of hand washing facilities;
- Medicines were not being safely prescribed and administered on HDU;
- The level of nurse to patient ratio on HDU did not meet core standards for critical care services during the initial inspection;
- The arterial blood gas analyser machine (which measures the amounts of oxygen and carbon dioxide and the acidity of the blood, used frequently on critical care units) was not available on HDU.
- However, in response to concerns we raised, the trust took immediate actions to address the areas of concern, including an urgent reconfiguration of the HDU to reduce the number of beds available to 11, while keeping the staffing the same so patients' needs were being met.
- Following this reconfiguration of the HDU, we returned during an unannounced inspection and found that the nurse staffing levels met core standards for critical care services (GPICS 2015), there were larger sized bed spaces and medicines were being safely prescribed and administered.
- Meetings to discuss morbidity and mortality for critical care patients had formally started in November 2015. This meant that discussions of any improvements and learning related to mortality and morbidity had not been taking place formally until recently.

We also found;

- There was a low number of low or no harm incidents reported by critical care services which indicated that staff were reporting proactively to prevent avoidable harm
- There was a good track record related to incidence of infection for critical care services.

### Incidents

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- The critical care units used the trust's electronic reporting system to record and report incidents.
- There was one serious incident reported by critical care services through the Strategic Executive Information System (STEIS) between January 2015 and January 2016. This was related to a resuscitation incident that occurred on ITU in September 2015 which had not initially been deemed as a serious incident. We were told that due to further information being reviewed by the trust's serious incident panel, it was decided that the criteria for a serious incident had been met. At the time of our inspection a lead investigator had been appointed and investigation and report in progress.
- 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. Overall, staff felt that when they had reported incidents they received feedback either verbally or via e-mails. There were quality notice boards on both units, which were used to raise awareness about incidents that had been reported. This meant there were processes and procedures in place for staff to learn from incidents.
- HDU reported 232 incidents in the 12 month period ending September 2015. The largest category (103) was tissue viability such as the condition of patient's skin on admission to HDU and presence of pressure ulcers. ITU reported 103 incidents in the same timescale and over half (61) were documenting patients tissue viability. There was evidence of involvement of other teams in reviews, including tissue viability specialist nurses.
- Resuscitation incidents were seen to be discussed by the cardiac review panel that assessed whether the arrest was considered unavoidable.
- The majority (98%) of the incidents reported by critical care services were low or no harm incidents (328 out of 335). This indicated that staff were reporting proactively to prevent avoidable harm to patients.
- In November 2015 the service commenced mortality and morbidity meetings. We reviewed the minutes of these meetings and found that they did not reflect a standard agenda nor was there an action plan with timescales and outcome measures. Therefore, we were not assured that learning and improvements related to mortality and morbidity had taken place.

## Duty of Candour

- 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 were fully aware of the Duty of Candour regulation. We saw evidence that a serious incident under investigation had triggered the Duty of Candour process and correspondence with the family was in progress.

## Safety thermometer

- Data on patient harm was required to be reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It included hospital-acquired (new) pressure ulcers (including only the two more serious categories: stage three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). Three pressure ulcers were reported in the safety thermometer between December 2014 and December 2015. One patient had acquired the pressure ulcer in the community prior to admission. The remaining two patients that developed pressure ulcers within the hospital. We saw that the investigations found the pressure ulcers to be unavoidable.
- Patients were assessed for risks of developing venous thromboembolism (VTE) such as, deep vein thrombosis from spending long periods immobile on admission to critical care.

## Cleanliness, infection control and hygiene

- At the time of our inspection, the environment and equipment in the units were visibly clean and tidy. Bed linen was in good condition, visibly clean and free from stains.
- We observed adherence to hand hygiene, use of personal protective equipment (PPE) and all staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow). Hand sanitising rules for staff were followed on both units and we observed a high standard of practice from all staff. Staff followed trust policy by washing their hands between patient interactions and using anti-bacterial gel. This met guidance around safe hand washing from National Institute for Health and Care Excellence (NICE).

# Critical care

- Both units had demonstrated 100% compliance with monthly hand hygiene audits (April 2015 to September 2015).
- We observed that staff wore disposable gloves and aprons at the bedside when caring for a patient or, for example, for the management of fluids or waste products. Staff also used gel when entering and leaving the unit or moving between clinical and non-clinical areas.
- There was alcohol hand cleansing gels and hand washing facilities available on the units. However, the provision of hand washing basins did not comply with the Department of Health 2013 best practice guidelines for critical care facilities (Health Building Note HBN 04-02) standard, of a minimum of one washbasin per bed space. In ITU, there were six basins for seven bed spaces. In HDU, there were washbasins located in each of the side rooms. On the main area of HDU, there were three sinks for 13 patients' bed spaces. This posed a risk to effective hand decontamination and was not included in the critical care risk register. Alcohol hand cleansing gel units were found attached to every bed in HDU. During the unannounced inspection on 27 January 2016, the HDU was found to have undergone urgent reconfiguration, including reducing the number of beds available by four. This meant that while they still were non-compliant, the trust had reduced the risk with three washbasins for nine bed spaces in the main HDU area.
- Data reported by ITU to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) showed there had been no unit acquired Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia (infection in the blood) or clostridium difficile in the last twelve months (June 2015). However, HDU did not submit data to ICNARC. The trust confirmed there had been no incidence of these infections on HDU.
- There were side rooms available on both critical care units plus two 'pods' which were temporary rooms on HDU to provide some isolation facilities. However, they were not able to offer controlled airflows or lobby rooms for infection control and isolation requirements. This meant there was a risk of potential cross infection. This risk had been identified and was documented on the risk register. It was documented that the risk had been mitigated as far as possible within the current estates and that this would be fully addressed in the new critical care unit that was planned to be built.
- On HDU, we observed a patient being cared for in a side room due to possibility of infection. The nurse looking after them was also allocated another patient to care for on the main HDU. This was because the patients were classed as high dependency level (therefore the ratio was one nurse to two patients). However, this meant that the allocation increased the potential risk of cross infection.
- In November 2015, 98% of critical care nursing staff were up to date with training in infection control and prevention. This was better than the trust's target of (80%). However, information provided showed that 73% of critical care medical staff were up to date with infection control and prevention training. .
- There were annual infection prevention visits undertaken by members of the infection control team. The review of the units in November 2015 had highlighted minor concerns such as some items being found stored on the floor. These were addressed in an action plan. We found that items, including sealed packets of disposable blinds were being stored on the floor in the linen cupboard on ITU. This was brought to the attention of the nurse in charge of the unit, as this meant that the floor was not clear to allow effective cleaning. Items were removed from the floor immediately.

## Environment and equipment

- Storage areas were generally tidy. However, staff told us and we saw that storage space was a challenge on both units. Particularly, there was a lack of storage space for medical equipment and patients belongings. This was not documented on the risk register.
- Ceiling mounted hoists were not available in the units. However, portable hoists were available to assist staff in moving and handling patients.
- All checked equipment appeared to be well maintained, visibly clean and portable appliance tested (PAT). A PAT test is an examination of electrical appliances and equipment to ensure they are safe to use. The trust provided equipment logs that indicated that critical care equipment had been serviced and maintained appropriately.

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- The critical care units had appropriate equipment for use in an emergency. There were resuscitation drugs and equipment including a defibrillator and a difficult airway intubation trolley. There was a resuscitation trolley on each unit. The resuscitation trolleys containing the emergency equipment had closed drawers, which once checked had anti-tamper tags attached. These had a serial number that was also recorded. This should be checked for security on a daily basis and the full contents checked on a weekly basis. Records showed that there was an occasional gap in daily checks on both units. For example, on HDU, checks were not fully completed on 24 occasions in six months. However, the trolleys had the full contents checks taking place regularly. During the unannounced inspection, evidence of daily checking of resuscitation equipment was seen, including a general critical care equipment monitoring form, which acted as an additional prompt to check the resuscitation trolleys. This was signed consistently.
- There was a variety of mobile equipment available including haemodialysis/ haemofiltration machines, cardiac output monitors, portable monitors, defibrillator, non-invasive respiratory equipment, portable x-ray machine and portable ventilators. However, there was no arterial blood gas analysis machine (which measures the amounts of oxygen and carbon dioxide and the acidity of the blood, used frequently on critical care units) available on HDU. Instead, samples were sent to the laboratories to be analysed. This meant there was a risk of delay in receiving results, which were required to tailor treatment. This was not documented on the critical care risk register although it had been discussed in a critical care delivery group meeting in September 2015 and a meeting with the trust's point of care team was to be arranged.
- There was a range of disposable equipment available in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times. None of the waste bins or containers for disposal of clinical waste or sharp items were unacceptably full and waste segregation was appropriate.
- On HDU, a trolley was found outside a side room for infection control reasons. However, this had patient identifiable data on charts and access to clinical supplies such as needles in drawers. This was highlighted to the matron and action was taken to ensure confidentiality and prevent access to the clinical supplies. There were no trolleys found outside of side rooms on HDU during the unannounced inspection.
- The units did not meet many of the national recommendations of building guidelines for modern critical care units (Health Building Note HBN 04-02). The recommendations were produced for all units managing the care of patients who met the level two (HDU) or level three (ITU) classifications. For example, on HDU, there was insufficient space around the patient's bed; monitoring equipment was not on ceiling-mounted pendants and there were no isolation facilities with specialised air handling. The trust described the HDU environment as a challenging working environment and acknowledged the lack of components associated with modern facilities due to the constraints of the existing building structure. The HDU bed spaces were 6.72m<sup>2</sup> rather than the recommended 25.5m<sup>2</sup>. This meant there was not enough space to allow five members of staff to attend to the patient in an emergency situation. During the unannounced inspection on 27 January 2016, the HDU was found to have undergone urgent reconfiguration, including reducing the number of available beds by four. Beds and bedside equipment had been removed and curtain tracks adjusted for the new configuration. The trust informed us that the bed spaces were now 10m<sup>2</sup>. This meant there was now space to allow five members of staff to attend to the patient in an emergency situation.

## Medicines

- Medicines that required refrigeration were kept at the correct temperature. We checked the refrigeration temperature checklists in the units, which were signed to say the temperature had been checked each day as required. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported. All the temperatures recorded were within the required range.
- Medicines and intravenous fluids were stored appropriately on ITU. There were medicines stored in lockable cupboards located behind the staff base, which we found to be unlocked. They were in an area clearly

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visible on the unit, which was continuously staffed. A standard operating procedure that confirmed the area was exempt from the requirement to be locked was provided.

- The clean utility room on HDU was accessed by a keypad to ensure secure storage of medicines, which were also in locked cupboards. The ambient temperature of this room was being monitored daily and documented by staff. However, records showed that since August 2015, the maximum temperature was exceeded on almost a daily basis. We could not find any documentation to suggest that actions had been taken as a result of this nor was this captured on the risk register. We discussed this with senior nursing and pharmacy staff who explained that they had escalated the issue to management and measures had been taken to reduce the risk of the temperature having an adverse effect. This included stock control of medicines. During the unannounced inspection, we found the clinical room was much cooler and the maximum temperature had not been breached. There was also documented evidence that the pharmacist had taken copies of the temperatures recorded for their records for stock control.
- Some prescription medicines under the Misuse of Drugs legislation are controlled drugs (CDs). We found the CDs were managed in line with legislation and NHS regulations. The drugs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. Stocks were accurate against the records in all those we checked on the units
- The matron for critical care had a 'dashboard' which included monitoring the numbers of medication errors reported by HDU and ITU. Each month the narrative of the errors was included. For example, in November 2015 there were three errors related to practices on the units (one in HDU and two on ITU). This also showed that there were on average three medication errors reported in total each month (May 2015 to October 2015).
- We checked a total of 13 prescription charts on the critical care units. All of the prescriptions on ITU were dated and signed.
- On HDU, we found two patients insulin prescriptions were not signed by the prescribers yet doses had been administered by nurses. We saw that patients who used insulin were supported to continue to administer their insulin while in hospital. However, when the patient made an adjustment to the prescribed dose as they would do at home, the actual dose they administered was not recorded. This meant that medical staff were unaware of how much insulin was being used and had incomplete information on which to base decisions about further treatment. There was no policy in place to support safe self-administration although pharmacy staff told us there was a policy in development.
- On HDU, we saw that some patients were prescribed sedative medicines for agitation. One patient was prescribed the medicine to be administered on an 'as required' basis. We found no instructions on what it was for, how frequently to give it, or the maximum daily dose. Another patient was prescribed the medicine for agitation. Three routes were specified, either orally or by intravenous or intramuscular injection. The recommended dose varies according to the route of administration. However, the prescribed dose was the same in every case. We saw that both these patients had received an electrocardiogram (ECG) tests to make sure that it was safe for them to have the prescribed medicine. ECG is a test that can be used to check a patient's heart rhythm and electrical activity. However, the prescriptions did not include enough information. This meant that there was a risk that the medicine may not be administered safely.
- On HDU, we saw a prescription chart that had prescriptions for warfarin in two different places, leading to a risk that the dose could be duplicated. Warfarin is used to reduce the risk of blood clots and the dose must be adjusted carefully in line with blood tests. We drew this to the attention of the nurse in charge who arranged for one of the prescriptions to be deleted. Matron assured the inspection team that this had been carried out.
- A patient that we spoke with on HDU; complained that they had waited over two days to receive a prescribed nicotine patch. We informed the nurse in charge and this was resolved later that same day.
- The concerns relating to medicine administration and prescribing on HDU were raised with the trust during the inspection. In response, a team including those in senior medical, nursing and pharmacist roles, reviewed all of the patients on HDU. During this review, the team noted that some patients had multiple prescription charts. In addition, some patients' medicines were transcribed from an electronic prescription from the wards. This meant there was a risk that patients may not receive

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medicines as they were prescribed. The plan was to implement electronic prescribing on HDU within a month. In addition, a critical care pharmacist was to attend the new multidisciplinary ward rounds each day to consider patients prescriptions.

- All the patients' prescription charts (eight) were checked on HDU during the unannounced inspection. There was noted to have been significant improvements in the standard of prescribing and there was no evidence of sedative use. An ITU consultant confirmed that a critical care pharmacist was attending the new multidisciplinary ward rounds each day on HDU, which had commenced following the inspection. A new proforma was also being completed daily which, we saw in patients records. This prompted staff to consider prescriptions, particularly if patients required sedation. All raised concerns regarding medicines appeared to have plans in place to address them, or had been responded to. The service was now actively auditing the drugs records on HDU.

## Records

- Patient's healthcare records were stored securely in paper-based files in drawers at the bedside, which helped with maintaining confidentiality. We checked eight healthcare records in total on the critical care units. Overall, the documentation was contemporaneous, maintained logically and filed appropriately. Entries were signed and dated, however the author did not always print their name, designation or include their professional registration number. This meant that it might be difficult to identify the person who had reviewed the patient.
- The ITU and HDU had different paper based observation charts. Both charts included the patient's vital signs and fluid balance, The ITU chart also included:
  - emergency equipment checks
  - alarms settings check for ventilators
  - endotracheal and tracheostomy (airway) tubes checks.
- We checked four observation charts and found them overall to be well completed.
- The nursing assessment documents were also well completed overall. We saw completed entries for bedrail management, malnutrition screening, falls risk, stool assessment, patient manual handling assessment, wound and communication charts. Records

demonstrated personalised care and multidisciplinary input into the care and treatment provided. However, there were multiple assessment forms, which were sometimes duplicated following transfer from a ward to the unit, which meant that there was a risk that required assessments may not be completed.

## Safeguarding

- Overall, critical care staff were aware of their responsibilities to report abuse and how to find any information on the trust intranet, if they needed to make a referral. We spoke with a range of doctors and nurses who were able to describe those things they would see or hear to prompt them to consider there being some abuse of the patient or another vulnerable person.
- 98% of critical care nursing staff were up to date with training regarding adult safeguarding and level two children safeguarding (November 2015). This was better than the trust's target for this training which was 80%.
- Information and relevant contact numbers for safeguarding were seen on staff noticeboards and in public areas.

## Mandatory training

- Topics that were covered by the mandatory training for all staff included:
  - information governance
  - conflict resolution
  - health & safety
  - and moving and handling.
- Clinical staff also had to undertake other mandatory training including resuscitation.
- As of November 2015, over 95% of critical care nursing staff had up to date training in all the mandatory training modules, except for conflict resolution (only 78% of nursing staff had completed this module). The trust's internal target for mandatory training was 80%. Information about medical staff mandatory training completion has been requested.

## Assessing and responding to patient risk

- On ITU, 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 2015). Patients who

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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.

- On HDU, we found that patients were not always closely monitored. For example, an inspector had to intervene to maintain safety during the inspection, when a patient was taking a bandage off, unwitnessed by nurses, in an attempt to remove an arterial monitoring line. The nurse caring for the patient was also allocated another two patients, all of which had been classed as requiring level two (high dependency) care. This was not compliant with the core standards for critical care on our initial inspection. On the unannounced inspection, we found that patients were being cared for by the recommended levels of nursing staff and therefore were able to assess and respond to patients' needs in a timely manner.
- Bedside monitors were available to continually monitor patients vital signs including, ECG and oxygen saturations on both units. It was noted by inspectors that the monitors on HDU were often alarming. At one point, monitors were alarming in five patients' bed spaces concurrently with no urgency seen by nursing staff in response. This meant there was a risk of a delayed response to a deteriorating patient.
- When we returned to HDU during an unannounced inspection the HDU was found to have undergone urgent reconfiguration. The unit was quieter and alarms were not continually triggered.
- A Critical Care Outreach (CCO) team had been established to support all aspects of the adult critically ill patient, including early identification of patient deterioration outside of the ITU and HDU. The National Early Warning Score (NEWS) supported this process and was embedded into the hospitals electronic patient observation system. This system prompted a full set of observations to be input including:
  - temperature
  - heart rate
  - respiratory rate
  - blood pressure
  - level of consciousness
  - oxygen saturation.
- If a ward-based patient triggered a high risk score from one of a combination of indicators on the electronic patient observation system, a number of appropriate routes would be followed by staff. This included the

escalation for advice or review by the CCO. The CCO and the patient's medical team were then able to refer the patient directly to the ITU consultants for support, advice and review. The CCO team also attended cardiac arrest emergency calls in the hospital.

- The CCO provided cover from 8am to 10pm daily. The HDU also provided a service to assess patients who may require non-invasive respiratory support in the hospital and facilitate their admission to HDU. The plan was to amalgamate this service with CCO and provide 24-hour cover for the hospital from April 2016. We were informed that this plan had been approved and recruitment was to commence.

## Nursing staffing

- Nursing staff rotas were generated and managed via an electronic system. Trained nurses worked a 12.5 hour shift pattern and rotated on to night duty. The trust provided the funded and actual staffing establishments for the units these were 41.75 whole time equivalent (WTE) for the ITU and 44.85 (WTE) including healthcare assistants. At the time of our initial inspection, ITU staffing met patients' needs, but this was not the case in HDU.
- Nursing staff levels in ITU met the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. 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. We were told and we observed that the nurse in charge of ITU was always supernumerary (does not have a patient allocated to care for) leaving them free to co-ordinate the shift. This was reflected in staffing rotas.
- On HDU, nursing staff levels during the initial inspection did not meet the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Patients were not always being cared for by recommended levels of nursing staff. We observed one nurse had been allocated three patients to care for who needed high dependency care (level two). The recommended level of care was one nurse for two HDU patients.
- The HDU planned staffing level for day and night shifts was seven trained nurses. This level could not provide level two care ratios and a supernumerary nurse in charge. During the inspection, the HDU were not compliant with standard levels of care for critical care

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patients. HDU staff described working under pressure particularly related to staffing numbers and working with agency staff. We raised this with the trust at the time of our inspection who took immediate action to resolve the situation.

- When we returned during our unannounced inspection, we found that staffing levels met patients' needs on HDU. This was because four beds had been permanently closed and planned staffing numbers remained the same (seven trained nurses). This continuing level of staffing was confirmed by trust managers and reflected in rotas. This meant that staffing was in line with core standards (GPICS 2015) including always having a supernumerary nurse in charge of every shift on a critical care area.
- Due to band five nurse staffing vacancies across both units of 20%, there were bank and agency nursing staff employed by both units. Records provided showed that shifts for trained nurses were filled between 95% and 100% for both units (June 2015 to September 2015).
- Agency and bank nurses made between 19% and 35% of the trained nurse cover for HDU between October 2015 and December 2015. Agency and bank nurses made between 15% and 19% of the trained nurse cover for ITU in the same period. The core standards for critical care units (GPICS 2015) stated that agency staffing should not make up more than 20% of the trained nursing cover for a shift. We saw evidence that the matron for critical care, alongside senior nurses, considered and managed the potential risks of using agency staff. For example, the staffing of both units would be organised to ensure that agency nurses did not make up more than 20% of the overall shift numbers on either of the units. This was to reduce the overall potential negative impact on a shift and to comply with core standards for critical care services. Band 5 nurses were being actively recruited, with four new staff waiting to start employment. The senior team told us that they had recruited staff from overseas in recent years as well as locally in attempts to fill vacancies.
- We reviewed the induction checklists for three agency nurses and found that all had been completed fully. The induction checklist included explanation of duties, location of emergency equipment, and fire safety. However, at the unannounced inspection we found that an agency nurse on HDU had the induction checklist partially completed. This process had been interrupted

by an emergency admission. The senior nurse in charge was closely supervising them until the checklist could be completed. We spoke with the agency nurse and they were happy with the support they were receiving.

- There was good handover among nurses on both units. This started with a full nurse team handover. Following patient allocations, the nurse then took a detailed handover about patients at the bed space. We observed that this was a comprehensive handover and observation charts were used to structure this.

## Medical staffing

- The level of cover provided by medical staffing on the ITU was in line with professional standards and recommendations. Including:
  - there was a 24 hour a day, seven day a week consultant on-call rota and the trust stipulated all consultants must live within 30 minutes travel time of the hospital. Staff from a variety of disciplines told us and we saw evidence that the consultant was available out of hours.
  - there was usually an anaesthetist that specialised in intensive care covering the unit. Six of the seven consultants were fellows of the faculty of intensive care and the seventh had dual emergency care and intensive care specialist training.
  - the consultant to patient ratio was one to a maximum of seven, which was better than the one to 15 maximum standard.
  - the consultant rota provided continuity during their ITU week, with the day consultant working 8 am to 10pm. However, the national standards (GPICS 2015) state a consultant in intensive care medicine must undertake twice daily ward rounds and staff informed us that this was taking place (on both units).
  - the ITU consultants were supported by resident medical staff 24 hours a day. A trainee doctor confirmed that they felt supported and the consultant was available
  - the use of locum medical staff was rare. For example, there had not been any locum medical cover for critical care services in the three month period October 2015 to December 2015.
- The ITU consultants also provided oversight and had responsibility for HDU patients. The ITU team were responsible for reviewing and held admission rights to

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HDU. The HDU operational policy stated that the patient also remained under the care of their original team. The respiratory HDU patients remained under the review of the respiratory physicians.

- Medical and nursing staff were confused regarding which medical team to call for advice. A nurse told us that it depended on what the issue was; if it was patient deterioration they would call the ITU team, alternatively they would call their own original team. This meant that there was a risk that the escalation of concerns may not be made to the appropriate medical staff, causing delays.
- Following the inspection the trust stated that with immediate effect, the respiratory consultants with appropriate advice and support from ITU consultants and relevant physicians would care for all medical patients on HDU. Surgical patients would continue to be cared for by their surgeon with appropriate advice and support from respiratory consultants (with regards to medical care). The ITU consultant team retained oversight for both critical care units.
- Handover between medical staff was comprehensive. The on call team handover to the day team took place prior to the ward round commencing.

## Major incident awareness and training

- The trust had a business continuity plan in place, which covered all incidents with the potential of causing a significant interruption to services. The trust also provided a surge plan. This detailed a staged response to an increase in requirements for level three (ITU) care at the hospital, including which extra areas, such as theatres, could be utilised for extra capacity.
- All staff that we spoke with were aware of their responsibilities and action to take in an emergency for example, a fire. All staff received fire safety information and emergency preparedness and response as part of the mandatory training. Over 95% of critical care nursing staff had up to date training in all the mandatory training modules. Information about medical staff mandatory training completion has been requested.
- A fire risk assessment had been carried out in August 2015 on ITU. Outstanding actions included, training for fire wardens and fire evacuation drills. An update was provided by the trust and a fire evacuation drill had been carried out and further dates arranged. The fire

warden training had been cancelled in December 2015 and was now rescheduled for 23 February 2016. This meant that there was not a person trained in fire safety to advise the other staff.

- We found that a fire exit evacuation route to be partially blocked by a staff chair on HDU. This was brought to the immediate attention of the nurse in charge who resolved this. A fire risk assessment was carried out on HDU in December 2015. This identified that a fire exit sign needed to be fitted at the end of the HDU, which had been completed. The fire exit remained clear when we checked during the unannounced inspection.

## Are critical care services effective?

Good



Overall, we rated critical care services as good for effective because:

- The trust electronic observations system incorporating the National Early Warning Score (NEWS) complied with the recommendations within NICE Guidance 50- Acutely ill patients in hospital.
- Patients' pain scores were being recorded and appropriate pain relief was being provided on the critical care units.
- Care bundles (evidenced based procedures) were in place for the use of ventilators and central lines.
- The ITU contributed to the ICNARC database which had identified adult critical care bed occupancy was at or around the England average. The mortality ratio for the unit was within statistically acceptable limits.
- Patients in the unit were required to be screened for delirium using a recognised screening tool (CAM-ICU); however none of the patients on HDU had been scored for delirium (National Institute for Health and Care Excellence NICE CG83). However, all patients were found to have been assessed appropriately when we returned for an unannounced inspection.
- A practice development nurse was in post whose role supported both units with competency completion and induction of new nursing staff.

However, there were some areas that could be improved because:

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- The HDU did not contribute to the ICNARC database, which meant outcomes were not being benchmarked against similar services.
- 53% of nursing staff in ITU had obtained a post-registration award in critical care against the national target of 50% but this did not include HDU nursing staff.
- The service were unable to meet NICE guidance for rehabilitation of the critically ill patient due to further resources required to increase physiotherapy and follow up clinic provision.

## Evidence-based care and treatment

- Patients' care and treatment was assessed during their stay and delivered along 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. Critical Care Outreach (CCO) undertook audits to assess aspects of this. For example, a communication tool called Situation Background Assessment Recommendations (SBAR) was introduced as the preferred method of communication for both medical and nursing staff to use when escalating concerns to their seniors. The initial audit demonstrated that compliance had improved (in May 2015, it was 92%), however this dropped to 57% in November 2015. Actions were underway to reinvigorate the use of this tool. A re-audit was planned in April 2016.
  - The ITU was working towards NICE Guidance No: 83 – Rehabilitation of the Critically Ill Patient. The critical care unit were undertaking a review of the existing documentation, to improve the ability to audit against the NICE recommendations and ensure that compliance against all recommendations could be clearly measured. This was a recognised area for development by the critical care team and was documented on the critical care risk register. Physiotherapists explained that they were not able to provide patients with 45 minutes rehabilitation per day recommended in the guidance. During a critical care peer review in 2015, it was found that rehabilitation prescriptions were in place and included good programmes. However, a business case was required to increase therapy input for critical care.
- This was documented on an action plan with the completion date of April 2016. During the inspection we observed a patient on ITU being assisted to mobilise with physiotherapist support and a walking frame.
- NICE guidance also recommended that there should be a follow-up clinic for patients to determine if they needed further input after two to three months after discharge home. A clinic had been trialled in 2013 but funding had not been found to continue this service. This was documented on the risk register and considered unresolvable at a divisional level. The non-compliance with the guidance had been escalated to senior managers.
  - 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 ITU observation chart incorporated a sticker that was used to prompt best practice at ward rounds. This included whether the central venous access was still required, whether ventilator acquired pneumonia was suspected and sepsis trigger. Patients were assessed for risks of developing venous thromboembolism (VTE) such as, deep vein thrombosis from spending long periods immobile. There was a review of patients for risks of developing VTE and patients were provided with preventative care including compression stockings and sequential compressions devices in line with NICE guidance.
  - The ITU 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 will be cared for in a critical care unit. There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant and was based at the hospital. They directly supported the organ donation programme and worked alongside the clinical

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lead. The specialist nurse also supported a regional and community programme for promoting organ donation. The specialist nurse submitted data to the national audit regarding potential organ donors.

- The organ donation report for April 2015 to September 2015 showed that overall the trust achieved 84.6% referral to specialist organ donation nurse during this period (target 95%). Since October 2015 to 20 February 2016, the referral rate was 100%. The trust recognised that Luton is below the national average for families giving consent for donation (33% against the national 69%). The specialist nurse had been involved in highlighting the high proportion of refusals from black and minority ethnic patient's families and working with local community leaders to try and improve consent rates.
- The ITU followed NHS guidance when monitoring sedated patients, by using the Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of the patient for different responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). Obtaining a RASS score was part of administering the Confusion Assessment Method (CAM), a tool to detect delirium in intensive care unit patients. All the ITU observation charts had stickers to facilitate this assessment. This was supported by a delirium protocol flow chart that was available in a resources folder in every bed space.
- On HDU, we found two patients were receiving sedatives for periods of agitation. Neither of the patients had received a formal confusion assessment (CAM) and therefore care was not in line with the trust's delirium policy. There was no evidence of CAM being used throughout the HDU at the time of the inspection. Staff told us they had not started to use the delirium assessment. However, some of the nurses had received training. During the inspection, the matron for critical care was informed. Formal assessments were planned to be carried out.
- The concerns that sedation was used to manage confused patients without risk assessment or monitoring were also raised with the trust. In response, all of the patients on HDU were reviewed and the delirium policy circulated to the staff. A training programme for HDU nurses to use CAM had begun and plans were for all to be trained by the end of February 2016. During the unannounced inspection, we found

laminated copies of key points from the delirium policy and guides for undertaking a CAM, attached to every bed space trolley. There was also evidence of CAM being applied daily for all patients (the appropriate exceptions being a patient with low conscious level and two patients admitted within the previous three hours). All prescription charts were also checked and there was no evidence of sedative use during the unannounced inspection.

- The ITU team were meeting core standards relating to engaging, and participating in a critical care operational delivery network (ODN). They belonged to the East of England network and a senior nurse and doctor usually attended network meetings. Minutes for a variety of network meetings show that critical care are actively involved in the groups including the education and the patient transfer groups.
- The ITU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care patients nationally. They were also taking part in national care bundle audits regarding ventilator and central line care and associated infection rates.
- Each ITU bed space had a resource file with guidance and policies. These were found to be very well organised and up to date.

## Pain relief

- We observed that the presence of pain was assessed regularly and patients were provided with appropriate pain relief on both ITU and HDU areas.
- On both the units they used a pain assessment tool. This included the use of a scale out of 10 for severity of the pain and (on ITU) included a pictorial scale of sad and happy faces. This would be useful for patients that were unable to communicate verbally for example, due to critical care interventions. Pain assessment scores were documented on the observation charts.
- Both units scored highly (95% -100%) in the documentation nursing audit regarding pain management for the last six months ending December 2015.
- The critical care units had access to a team that specialised in acute pain. We saw the acute pain specialist nurse reviewing a patient on the HDU during the inspection.

## Nutrition and hydration

# Critical care

- Patient nutrition and hydration needs were assessed and effectively responded to. The patient records we reviewed were well completed, and protocols followed. Fluid intake and output was measured, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered.
- The method of nutritional intake was recorded and evaluated each day. Any feeding through tubes or intravenous lines was evaluated, prescribed and recorded. There were protocols for nursing staff to commence enteral feeding for critical care patients before discussion with dieticians.
- The patients that we spoke with mentioned that the quality of the food that they had been served whilst in hospital could have been better. We observed the food on HDU during the inspection and noted some burnt and dry food that looked unappetising.
- Substantive staff were competent in giving intravenous (IV) fluids. The trust policy was for all trained nurses commencing employment at the trust to attend IV administration training as part of their induction or as part of the preceptorship programme for newly qualified staff. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital. There was a process for agency staff who had previously completed their intravenous competencies at another trust; they would undergo an assessment by the practice development nurse prior to being allowed to administer intravenous therapy and medicines.
- Delayed discharges
- Unplanned readmission within 48 hours
- There was an audit clerk whose role included inputting ICNARC data for ITU. However, the HDU were not contributing to ICNARC, this meant that their outcomes were not being benchmarked against their critical care peers.
- Central line care audits results for ITU indicated a good level of compliance (93% – 100% January to October 2015). However, HDU data showed poor compliance with central line care bundles (January – October 2015 22% – 67%). An action plan to address this included increasing the frequency of the audits to twice weekly until improvements were seen in the results. The results for November and December 2015 showed 100% compliance with the nursing elements of the bundle, but the insertion checklist continued to be noncompliant. Medical staff were to be targeted to ensure they are aware of the need to fully complete the checklist. Copies of non-complete checklists were to be forwarded to managers of the surgical division for feedback to the clinician involved. The increased audit frequency of twice weekly was to continue until results improved above 90%.
- Local audits were undertaken each month related to nursing care documentation. Areas audited included :
  - communication
  - patient falls
  - fluid balance
  - nutrition
  - and pressure area care and manual handling

## Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in 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. Mortality indicators are integral to the ICNARC audit. The unit was performing as expected (compared to other similar services) in all indicators used in the ICNARC quality report (April 2014 to March 2015) including:
  - Hospital mortality
  - Out of hours discharges to the ward
  - Non clinical transfers (out)
  - Unit acquired infection in the blood
- The results for the last twelve months for both units indicated good overall performance (86-100%) in relation to most areas which included pressure area care and communication. A variable performance was noted related to documentation of nutrition on critical care units (53-97%) in nursing audits in the last six months ending December 2015. During the inspection we saw evidence of an assessment of the patient's nutritional status had taken place in six out of seven critical care healthcare records.
- The ITU governance lead consultant shared the ongoing audit programme for the surgical division. Aside from nursing, care bundles, and national audits there were

# Critical care

two clinical local audits listed for critical care areas. This meant that the service was undertaking audit to evaluate the effectiveness of aspects of care given on critical care.

## Competent staff

- Staff were required to be assessed each year for their competency, skills, and development. The appraisal rate for ITU (excluding medical staff) was 86% for January 2016. This was less than the trust's target of 90%.
- Medical staff have to undergo revalidation in order to remain on the General Medical Council (GMC) register. Critical care had nine consultants, eight of which have revalidated (as of February 2015) and one who is due to revalidate in 2018. There were also 11 staff grade doctors in critical care, six of which had revalidated (as of February 2015) and five are working towards achieving this. The trust maintained that the doctors were working within the GMC revalidation guidelines and will be able to revalidate in line with the scheduled date agreed with the GMC. The trust had established processes and procedures that were communicated to doctors who were required to revalidate. Information regarding the status of appraisal for critical care medical staff has been requested from the trust.
- A practice development sister, who was a senior ITU nurse, provided a support role regarding professional development. This support was provided to both units, in line with core standards for critical care services.
- We were told and we saw evidence that new nursing staff to the critical care units received a period of time where they were supernumerary (extra to the clinical numbers). This was in line with core standards (GPICS 2015). Generally, it was between four weeks, although the length of time varied dependent on the individual's needs. New staff to the trust also had general induction study days to attend. Clear induction processes were described and supported by documentation that we saw during the inspection, including allocated mentors and orientation meetings that were completed in this period.
- Core standards state that a post registration award in critical care should be held by at least 50% of trained staff and the ITU met this (58%). However, the core standards also apply to level two (HDU) areas. Therefore, critical care services overall were noncompliant as the HDU staff did not hold this award. HDU staff had expressed an interest in undertaking the

ITU course and two staff were identified to begin studies. However, the university had been unable to provide the course and withdrew the course at short notice. An alternative post registration award provider was being explored.

- Critical care nurses and critical care outreach team were working through the national competency framework for adult critical care nurses. A standardised three staged approach to development of critical care nurses.

## Multidisciplinary working

- Critical care services particularly ITU, had input into patient care and treatment from physiotherapists, pharmacists, dieticians, speech and language therapists, microbiologist (a healthcare scientist concerned with the detection, isolation and identification of microorganisms that cause infections) and other specialist consultants and doctors as required. All the professionals we spoke with described positive working with the ITU team. Weekly multidisciplinary team (MDT) ward rounds were held on Wednesday mornings for ITU patients. During the inspection this was attended by staff from microbiology, pharmacy, physiotherapy, occupational therapy, dieticians as well as medical and nursing staff from ITU. All members of the MDT ward round were encouraged to express their opinions and a plan of action was drafted for each patient reviewed. This MDT ward round did not include HDU patients. During the unannounced inspection, we found that a daily MDT ward round had commenced on HDU. This included the ITU and respiratory medical team and critical care pharmacist.
- Evidence of referring to other professionals for advice was observed during a consultant led ward round on ITU. For example, advice was sought from speech and language therapist and maxillofacial surgeons for a patient who had a history of difficult airway placement.
- The CCO service covered the hours of 8am to 10pm daily. Plans had been approved to extend this cover to 24 hours a day from the 1st April 2016. They did not review all patients that were discharged from ITU and HDU. In the three months ending January 2016, 63% of ITU and 57% of HDU patients were seen by CCO following discharge. These numbers did not include patients who were ready for ward care for more than 24 hrs. This meant there was a risk that patients and staff

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were not always receiving expert support with aspects of recovery from critical illness. The trust informed us that the risk of not all discharges seen routinely by CCO was mitigated by;

- reviews undertaken by medical and nursing ward staff and appropriate patients would be referred to the CCO team
- an electronic patient observation system was reviewed daily by the CCO team to identify patients who may be deteriorating
- follow up telephone support calls were made to the ward

HDU staff told us they referred patients to CCO to be reviewed after transfer to a ward if they had any ongoing concerns.

## Seven-day services

- The CCO provided a seven day a week service covering the whole trust. There were plans to provide a 24 hour service from April 2016.
- Physiotherapists visited the units every day. Physiotherapists were available overnight, via an on call system. Frequent physiotherapy reviews were seen documented in health care records; including reviews of patients at the weekend.
- The unit received input and support from dieticians, pharmacists and occupational therapists during weekdays. There were protocols for nursing staff to commence enteral feeding on ITU patients out of hours.
- Staff told us that at the weekend, the consultant attended the unit and was available. We saw evidence in patient healthcare records of consultant led ward rounds being documented, including at the weekend. Overnight a critical care consultant (on-call) was available for advice and assistance. The clinical lead consultant confirmed the on call consultants could be available within 30 minutes and this formed part of the terms of the consultant's employment.
- Critical care medical staff felt that the consultants were supportive and were available for advice, including out of hours. During the unannounced inspection we talked with the on call critical care consultant. They were reviewing patients on HDU until 9pm and handing over to the registrar. The consultant maintained it was not unusual to be present at the hospital at this time.

- Access to other allied health professionals including, podiatry, speech and language therapist and psychology operated on a 'by referral' system during weekdays.

## Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their critical care stay. Healthcare records at the trust were electronic with paper based current admission records available at the patient's bedside.
- The majority of information, including results from patient tests and guidance was available via the trust's intranet.
- During ward rounds a computer was accessed to check blood and diagnostic test results, to guide treatment plans.

## Consent and Mental Capacity Act

- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- 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.
- Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the trust. Over 95% of critical care nursing staff had up to date training in all the mandatory training modules (November 2015).

## Are critical care services caring?

Good



Overall, we rated critical care services as good for caring because:

- Throughout the inspection people using the service, including patients and their families were positive about the care they had received.
- Feedback collected from patients and their families was positive about the care and treatment they received on the critical care units.
- Staff involved patients as much as possible in decision making and keeping them informed about progress with treatment.

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## Compassionate care

- All the patients and relatives we met spoke highly of the care they received on the units. 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 said staff were caring and compassionate
- We observed many caring and compassionate interactions between staff on the critical care units of all disciplines and the patients in their care. During the ward round, medical staff talked to patients (including those that were sedated), and explained what was happening to them.
- We observed attention from all staff to patient privacy and dignity. Curtains were drawn around patients and doors closed when necessary.
- Both units actively sought feedback from patients and relatives. This was collected via forms which were collated and summarised for the teams. There were many positive comments seen on the summaries (August to October 2015) for example, describing the team as heroes and expressing gratitude. During the ward round a patient who was waiting to be discharged to the ward handed in their completed patient feedback form. They expressed how extremely pleased they had been with the care they had received in ITU.
- The trust provided three examples of complimentary letters they had received from patients and their family (September to October 2015) regarding the care received on HDU.

## Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. We observed staff, both doctors and nurses talking inclusively with patients and their relatives.
- On HDU, the inspector intervened when a member of medical staff began discussing a patient's progress with relatives, whilst stood in another patient's bed space. This was breaching confidentiality because the

conversation could be heard by another patient. Immediately this was brought to the doctor's attention and the conversation continued away from the patient area.

- The views of relatives and carers were listened to and respected. One patient that we spoke with said that they had always been kept updated of progress by staff on ITU.
- Patients that were conscious were fully involved in discussions during ward rounds, they were listened to, and opportunity to ask questions was provided.

## Emotional support

- The critical care team demonstrated that they appreciated the emotional turmoil that patients and relatives experienced due to critical illness and critical care admission. They provided a supportive, kind and unrushed approach.
- Chaplaincy support could be arranged if required and information about this was also provided in the relative's waiting room.
- There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant and was based at the hospital, to directly support the organ donation programme and work alongside the clinical team.
- We were told that bereaved relatives of patients that died on ITU were invited to services held in the hospital chapel. However, the trust had informed us that the service has not been able to take place for the last two years for a number of reasons. ITU staff send a condolence card to the family of any deceased patient during the month after to keep in touch. The services are planned to restart in April 2016.
- There was no follow up clinic for supporting patients after critical illness. However, the critical care outreach team could access psychology services if required.

## Are critical care services responsive?

Good



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

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- There was provision of facilities for visitors to the ITU, including a waiting room, hot and cold drinks, toilet facilities and a private room, which could be used for discussions.
- ITU performed within expected levels for delayed discharges when compared with similar units in the 2014/2015 ICNARC quality report.
- The ITU was performing as expected when compared to other similar services regarding transferring patients from ITU to a ward overnight (ICNARC June 2015).
- At a unit level there was acknowledgement and recording of mixed sex occupancy and consideration of bed capacity and patient flow demands.

However there were some areas that could be improved because:

- On average, 25% of patients were being transferred from HDU to a ward overnight (six months ending December 2015).
- Available translation services were not always accessed for patients who needed them. We found that staff were using patients' relatives to translate for staff on HDU.
- Visitor's facilities were limited on the HDU, with a small waiting room and no access to drinks or toilet facilities. There were also limited facilities for private discussions such as for breaking bad news.
- At a unit level there was acknowledgement and recording of mixed sex occupancy.

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

- The critical care services over recent years had developed to meet the needs of local people. The service had seen the amalgamation of a separate respiratory and general HDU beds into one unit two years ago. However, the ITU and HDU were constrained by existing estates.
- The critical care units did not meet many of the recommendations of the Department of Health guidelines (HBN04-02) for modern critical care units as they related to meeting patient needs and those of their visitors. These included:
  - bed spaces in HDU were incapable of giving reasonable auditory privacy
  - there were no facilities for patients who were well enough to have a shower or use a toilet on ITU

- lack of separate entrances to the units from within the hospital corridors to ensure visitors did not observe patients arriving and leaving the unit
- relatives' facilities were limited on the HDU, with a small waiting room and no access to drinks or toilet facilities. There were also limited facilities for private discussions such as breaking bad news.
- However, at the unannounced inspection, the HDU had reduced the number of bed spaces by four. This improved the potential for auditory privacy due to more space being available between patient's bed spaces; there was intercom-controlled entry to both units. Entrances were locked and could only be opened by authorised hospital staff
- There was provision of facilities for visitors to the ITU. Visitors had access to a waiting room, and an area in which hot, and cold drinks were available. This was located just outside the unit for visitors to wait or to enable visitors to step away from the unit if they wanted a break. There were toilet facilities and a private room, which could be used for discussions.
- Visiting times were between 2.15pm and 7.15pm each day. However, they could be flexible to meet the needs of the patient and their loved ones. The policy was for only two visitors per bed space. There was limited space on the units and visitors were asked to restrict numbers where possible. We spoke with some visitors waiting to go on to the HDU. They confirmed that the staff had been flexible and allowed visiting outside of the set times.

## Access and flow

- The ITU had seven physical beds, six of which were funded and staffed for intensive care patients (level three) and high dependency care (level two). The seventh bed was for post major elective surgery such as maxillary facial procedures and was staffed according to need. An operational policy describing elective and emergency admission procedures for the ITU was provided.
- The HDU had 15 physical beds, six of which were for respiratory (level two) patients and the remaining for high dependency care (level two). An operational policy describing elective and emergency admission procedures for the HDU was also provided. During the unannounced inspection on 27 January 2016, the HDU was found to have undergone urgent reconfiguration,

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including reducing the number of available beds by four. There was also a decision not to separately manage respiratory HDU beds. The respiratory medical team were to manage all the patients on HDU with input and advice from other teams such as surgery and ITU.

- There was a process for booking beds on the units for critical care following elective surgery. The details of the cases were booked in advance into the unit's diary. The ITU operational policy made it clear the responsibilities to ensure that a limit of one elective case per day was booked.
- The HDU operational policy stated similar responsibilities, including a maximum limit of two patients undergoing bariatric surgery per day. However, the HDU diary was checked and was found to contain up to five elective cases booked per day on occasions. Staff on HDU told us that there was not a set limit to how many elective cases could be booked each day. This meant that there was a risk that more patients could be booked than there was capacity for.
- The number of elective surgery cases cancelled due to lack of availability of a post-operative critical care bed on HDU for the last 12 months ending January 2016 was four. There were no cancellations, of this type, due to lack of ITU bed availability in the same time period.
- The ITU had around 35 patient admissions per month (12 months ICNARC data ending March 2015). Over half of the patients were ventilated (level three) on admission. The critical care bed occupancy (81%) was below or around the England average of 84% (NHS England December 2014 and November 2015). HDU had around 64 patient admissions per month in the twelve months ending December 2015.
- There were issues related to delayed discharges on both units. When a patient no longer required critical care and was deemed fit to transfer to a ward area, it could be over 24 hours before the transfer to a ward occurred. For example, on ITU on 20 January 2016 there were three patients waiting for discharge to a ward. One patient had been waiting for two days. Similarly, there were patients waiting for ward beds on HDU during the inspection. ITU performed within expected levels for delayed discharges when compared with similar units in the 2014/2015 ICNARC audit. However, this potentially may delay admission of patients requiring critical care.
- Emergency admissions were required to be referred between consultants if possible. A patient requiring critical care should be admitted within four hours of the

decision in order to comply with core standards for critical care (GPICS 2015). Six healthcare records were checked on ITU and five patients had been admitted within four hours of the decision to admit time and one was unclear. Data submitted to the critical care network by the trust showed that for the three month period ending December 2015 between 95% and 99% of patients were admitted to HDU within four hours.

- The trust supplied details of two occasions when patients were ventilated outside the ITU due to bed pressures since October 2014. They both occurred in October 2015 and the patients were cared for in theatres until they could be admitted to the ITU.
- There were five incidents electronically reported in July 2015 relating to delayed admissions to HDU. The divisional director for surgery reviewed the incidents and found all but one related to availability of isolation rooms and no patient harm was identified. One of the incidents involved a maternity patient who met the criteria for admission to the HDU. A HDU bed was not available. The patient remained in the maternity department and received care there including an insertion of a line into the artery, to enable monitoring of blood pressure and blood gas analysis (which measures the amounts of oxygen and carbon dioxide and the acidity of the blood, used frequently on critical care).
- Due to the delays experienced in accessing ward beds when required, there were patients that were transferred out from ITU to a ward during the night. The core standards for intensive care units (GPICS 2015) stated, discharge should occur between 7am and 10pm. Discharge overnight has been highlighted as an event that adversely affects patients' experience (East of England Critical Care Network, Quality Data Definitions 2015). Twelve patients were transferred to the wards out of hours from ITU between January 2015 and June 2015. The ITU was performing as expected when compared to other similar services (ICNARC June 2015). However, HDU transferred on average 11 patients a month overnight (six month period ending December 2015). The HDU during the same period had on average 44 discharges a month. This meant that on average 25% of discharges from HDU took place between 10pm and 7am (six month period ending December 2015). The trust stated that it was working with the clinical staff on HDU to improve the early identification of patients who may be ready to step down to a ward bed. This is to

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reduce the number of patients transferred out of hours. The trust maintained that all transfers from HDU between 10pm and 7am was in direct response requests for emergency admission or sudden deterioration of ward patients.

- There was one transfer out of ITU due to non-clinical reasons between January and June 2015 according to ICNARC data. The nature of most critical care units meant there was often limited opportunity to provide single-sex wards or areas and this is not required until they are considered ready for discharge to a ward. Staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. However, we observed many examples of patients that were ready for the ward, in beds directly opposite or next to members of the opposite sex. The patients did not have access to segregated toilet facilities on HDU. We raised this with the trust who took immediate action to resolve the situation.
- At the unannounced inspection, we found that when patients were ready for a ward where possible they were being cared for in the HDU side rooms, to improve dignity and privacy. We were told by senior nurses that after a patient has been deemed ready for step down transfer to a ward and would be staying overnight on a critical care unit, a mixed sex occupancy breach would be reported. This included the nurses completing a form capturing the issues including, the reason for delayed discharge and the type of ward bed required for onward care and emailing this to the matron for critical. A folder was seen on both units where these completed forms were stored. Information was collated and reviewed by senior managers and reported to the CCG to help inform bed capacity considerations.
- However, the official number of reported breaches for critical care was nil (between April 2014 and December 2015). This was discussed with the matron. They stated that if a patient was waiting for a specific speciality bed then breach declaration was not required. The trust policy was provided and it included a local agreement with the clinical commissioning group. It stated that for critical care, it might be clinically justified in the majority of cases for the patient to remain within that environment to ensure their safety and high quality care. This meant that at a local level there was acknowledgement and recording of mixed sex

occupancy. The trust told us that if situation arose when a suitable bed was available, and the patient did not transfer, then this would constitute a breach and be formally reported.

## Meeting people's individual needs

- Patients were provided with call buzzers. Buzzers were observed to be answered promptly when used. A patient waiting to be transferred to a ward on ITU had been provided with a nurse call buzzer. This was within reach and could be used to request assistance.
- Communication tools to assist patients were available such as, non-verbal pictorial charts. Those patients unable to communicate for example, due to airway tubes being in place, could use these.
- Staff told us that they could access interpreters for patients that spoke different languages and signposted us to information on the trust's intranet. However, there was a patient being cared for on HDU for whom English was not their first language. When this was discussed with nursing staff, they maintained that the patient's relatives were translating for the patient. This was not best practice.
- Staff were able to describe the specialist support available at the trust for patients with learning disabilities. 'This is me' booklets were also mentioned by staff. These booklets offered a practical way of informing staff about the needs, preferences, likes, dislikes and interests of a person. These can be particularly useful when caring for someone living with dementia. During the consultant led ward round on ITU a patient was referred to the learning disabilities team for advice and support.
- There was a good range of booklets, leaflets and information for both patients and families. For example, leaflets about ITU, and people living with dementia. These were all provided in English. However, there were general information leaflets regarding hospital admission in a variety of languages for example, Bengali.

## Learning from complaints and concerns

- The critical care units received five formal complaints in the twelve months (January 2015 onwards). They were cases that did not necessarily reflect on the care

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provided on the units. However, communication between relatives and nursing staff on HDU could be improved. This was raised and discussed at team meetings by the unit manager.

- Staff were able to discuss the trust's complaint procedure and local escalation to senior nurses in critical care. We saw there were leaflets available for patients, visitors and relatives on how to make a complaint.

## Are critical care services well-led?

Requires improvement 

Overall, we rated the critical care services as requires improvement for being well-led because:

- Critical care services were led by a matron and a clinical lead consultant. Challenges and risks regarding HDU were understood by leaders prior to inspection. One of the actions taken after we raised concerns was to refocus the leadership for HDU, with the matron taking a senior nurse role, until improvements were firmly embedded.
- The same senior staff managed both the ITU and HDU. However, they were not operating as integrated services and had separate rotas, study days, charts and operational policies.
- There was a lack of knowledge of the vision for the services demonstrated by staff.
- Risk management and quality measurements could be strengthened particularly by submission of HDU data to ICNARC.

However we also found :

- We saw evidence of critical care delivery group and directorate meetings being held. Within the minutes of these meetings, we saw evidence of incident reporting, staffing and performance indicators being discussed.
- Critical care services had a risk register where risks were documented, reviewed and updated.
- We saw evidence of good team working and staff morale.

### Vision and strategy for this service

- A clear vision for the whole critical care service team for the future was not evident from discussions with staff.

Senior staff described the steps that had happened two years ago to integrate two separate teams HDU and respiratory, into one HDU department. This had been achieved and staff integrated into one team.

- The HDU was separate physically from the ITU, being on different levels of the hospital. The units also appeared to operate in isolation with separate staffing rotas, observation charts, and study days. There had been some rotation of staff between the units and further rotations were planned. However, it was acknowledged by senior staff that further work was required in order to integrate these two critical care departments.
- Staff were aware of the plans for a new combined critical care 30 bedded unit to be built at the hospital and were looking forward to it.

### Governance, risk management and quality measurement

- There were separate operational policies in place for the units with guidelines for the services.
- The ITU contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland as recommended by the faculty of intensive care core standards. The HDU did not participate in a national audit reporting database. This was despite the core standards not differentiating between ICUs and HDUs when recommending contribution to, for example, ICNARC. Participation would have meant the HDU being able to show patient outcomes and other quality data benchmarked against other similar units.
- The clinical governance/audit lead consultant for critical care was unable to share any evidence of improvement from audit activity undertaken.
- The mortality and morbidity meetings had formally begun in November 2015. The minutes of the meetings minutes did not include timescales or outcomes for any actions or recommendations that were identified.
- There was a risk register, which contained the risks for both critical care units. The lack of side room facilities and negative pressure rooms were the highest rated risks for the units. The new facilities were planned to meet these needs. The geographical split locations between HDU and ITU were also documented as a risk. There was evidence that risks on the register were being reviewed and updated. However, there were issues we found during the inspection that had not been documented on the register. For example the lack of

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blood gas analyser equipment being available on HDU, a critical care area. This meant that risks were not being documented consistently, to allow escalation of those that could not be dealt with at a local level.

- Prior to the inspection, the trust described the HDU as having a challenging working environment. Including:
  - cramped bed spaces that were challenging for patients and clinicians
  - equipment had to be wheeled in to support patients in already constrained bed spaces
  - limited space for relatives to sit when visiting
  - limited support facilities for patients and relatives, with a lack of waiting and quiet facilities to break bad news.
- We also found on HDU:
  - poor management of privacy and dignity for patients waiting for ward care
  - lack of application of delirium policy and formal confusion assessment
  - prescribing discrepancies including high risk medicines
  - nurse staffing level could not provide level two cover plus supernumerary nurse in charge.
- Issues related to HDU were also discussed in the critical care delivery group (CCDG) meeting in June 2015. These included discussions regarding confusion regarding medical management responsibilities and poor patient flow in and out of the HDU. However, it stated that this was the first CCDG meeting since 2013. The requirement for a CCDG was noted following a peer review in January 2015.
- When the risks of the HDU environment were raised during the inspection, the trust maintained that they had planned to reduce the number of beds on the HDU by two but had not achieved this. At the unannounced inspection the HDU had undergone urgent reconfiguration and reduced the number of physical bed spaces by four. This meant that the risks had been identified by the trust but actions had not been taken to address these prior to the inspection.
- At a unit level there was acknowledgement and reporting of mixed sex occupancy. The official number of reported breaches for critical care was nil (between April 2014 and December 2015). The trust policy was provided and it included a local agreement with the clinical commissioning group.

## Leadership of service

- Critical care services (both ITU and HDU) were under the management of the surgical division. Locally they were led by a matron 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 accessible and experienced. Throughout the inspection, they responded appropriately to incidents and areas that required immediate action.
- However, despite the ITU and HDU having the same leadership team, there appeared to be different standards of service provided. For example, there were numerous concerns regarding HDU that we raised during the inspection. Following this, the trust took immediate actions including, refocussing the leadership of the HDU.
- We were informed that the matron for critical care would be taking on the daily operational senior nurse role for HDU until all improvements were undertaken and firmly embedded. These changes included:
  - using side rooms for patients waiting for ward care
  - completion of training programme for nurses to use delirium screening confusion assessment tool
  - implementation of electronic prescribing within one month
  - all medical patients to be cared for by respiratory consultants with appropriate advice and support from ITU consultants. Surgical patients were to be cared for by their surgeon with support and advice from respiratory and ITU consultants.
- On the unannounced inspection, we observed the ITU consultant was present on the HDU reviewing all the patients and handing over to the on-call doctor. The ITU team were retaining the admission process to the HDU because of their knowledge of elective patients requiring admission as well as the overview of the ITU bed state. This meant the ITU consultant to patient ratio, including the newly reconfigured HDU, was one to a potential 18, exceeding the one to 15 maximum standard (GPICS 2015)
- Clinical leadership of the patient's treatment and care was good from nurses and medical staff. During site visits, the nurse in charge of ITU was always supernumerary (did not have a patient allocated to care for), leaving them free to co-ordinate the shift. However, the nurse in charge of HDU also had taken care of

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patients. According to core standards for critical care units there should always be a supernumerary nurse available. Also, as a minimum requirement, those units that have more than 10 beds, (HDU following urgent reconfiguration had 11 physical beds) must have a further additional supernumerary nurse (core standards for intensive care). This standard was not being met.

## Culture within the service

- A strong supportive teamwork culture was evident within each unit. A critical care doctor we spoke with described the unit as having a supportive, friendly atmosphere, which made it an enjoyable place to work.
- The nurses in particular appeared to have a good rapport as a team and were patient focused. However, they did not describe themselves as one critical care team.
- The ITU and HDU appeared to have different cultures. Staff commented that they were very different places to work. This may be due to the environmental conditions that the staff were working in. The ITU appeared calm and controlled. HDU felt loud, busy and chaotic. When we returned during the unannounced inspection, the nurses expressed gratitude to the inspectors because the working conditions had improved. A nurse told us that they felt able to provide a better standard of care to their patients following the reconfiguration of the beds.

- The clinical governance meeting for anaesthetics and critical care dedicated a presentation and discussion to the Duty of Candour regulation.

## Public engagement

- There was limited evidence of public opinion being sought within the unit. However, feedback forms were present in the relatives' rooms to complete. Also patient's feedback was requested when they were ready for discharge to a ward. All the responses were summarised and shared with critical care teams.

## Staff engagement

- There was a structured approach to nursing teams within the ITU and HDU. Staff were allocated into sub teams. This meant that a senior nurse had a team of nurses allocated to them to support. These teams were also used for appraisals and training development days.
- Staff took part in the trust's engagement events. These were fondly referred to as 'tent days' as a gazebo was used for the events. Most staff we spoke with felt that these events gave them the opportunity to provide feedback to managers of the trust.

## Innovation, improvement and sustainability

- The CCO lead was passionate, dynamic, and knowledgeable and improvement focussed. The plans to increase to 24-hour CCO service would bring them in line with core standards for critical care services.

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Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Luton and Dunstable University Hospital NHS Foundation Trust provides maternity and gynaecology services at Luton and Dunstable Hospital. The hospital has an eleven-bedded consultant-led maternity unit as well as a four-bedded midwifery-led birthing unit (MLBU) with birthing pool. There is an antenatal clinic in the hospital as well as an early pregnancy unit and a day assessment unit (DAU).

There is a triage system in operation. The hospital has a 26-bedded antenatal ward (Ward 32), which includes eleven triage beds, a 29-bedded postnatal ward (Ward 33) and an 18 bedded gynaecology ward (Ward 34). The maternity unit has two dedicated theatres for elective and emergency surgery for maternity and gynaecology. (Triage is the process of determining the priority of pregnant mothers' treatments based on the severity of their needs).

The hospital provides outpatient clinics and services, which includes uro-gynaecology, uro-dynamics, fertility, hysteroscopy, colposcopy, termination of pregnancy service, endometriosis service, early pregnancy clinic, specialist recurrent miscarriage services and a foetal medicine service.

The hospital employs community midwives, who care for women and their babies both during the antenatal and postnatal periods and provide a home birth service. The community midwives are aligned to a local GP practice. The hospital has expanded the services of midwife led clinics into the Leighton Buzzard area.

The trust reported 4,867 births between July 2014 and June 2015. Of these, 57% were normal (non-assisted) deliveries, which is comparable to the England rate of 60%. Additionally, 11% were elective caesarean deliveries, which is in line with the national average and 17% were emergency caesarean deliveries, which is slightly above the England average of 15%.

The hospital also provides a termination of pregnancy service (TOP service). The trust reported that they carried out 92 medical terminations between April 2014 and March 2015, and three surgical terminations between April 2014 and March 2015.

During our inspection, we spoke with 10 patients and their relatives. We also spoke with over 60 members of staff, which included midwifery staff, nursing staff, medical staff, clinical leads for maternity, clinical leads for gynaecology, divisional managers, head of midwifery, senior nurse for gynaecology service, service risk manager and the safeguarding lead midwife. We observed care and treatment and looked at eleven care records. We received comments from our listening event and we reviewed the trust's performance data.

We also carried out an unannounced inspection to the service on 4 February 2016.

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## Summary of findings

Overall, we rated maternity and gynaecology services as good for safety, responsive, caring, effective and for being well led because:

Patients were protected from the risk of avoidable harm and, when concerns were identified, staff had the knowledge and skills to take appropriate action. Incidents were recorded, investigated and, where necessary, actions were taken to prevent recurrences.

Environments were visibly clean during the inspection and the service had robust infection control systems in place. Equipment was generally checked regularly and well maintained.

Medicines were stored and handled safely. Records were completed and stored in accordance with trust policies.

Safeguarding vulnerable adults, children and young people was a priority for the service. We saw staff responded appropriately to signs or allegations of abuse and worked effectively with others to implement protection plans. There was active engagement in local safeguarding procedures and we saw effective work with other relevant organisations during the inspection.

Doctor, nurse and midwife staffing levels and skill mix were planned, implemented and reviewed regularly. Staff shortages were responded to quickly and appropriately. There were effective handovers at shift changes to ensure staff could manage risks to patients.

Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Information about patients' care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Access to medical support was available seven days a week throughout the service.

Feedback about the service and staff was largely positive. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were largely positive. Staff responded compassionately when people needed help and supported them to meet their basic personal needs as and when required. People's privacy and confidentiality was respected.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided.

The service consistently met the 92% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment for gynaecology. Patient flow in the service was generally effective.

Governance arrangements were effective and there was a clearly defined strategy and governance structure in place.

However, we also found that:

Not all staff had received an appraisal or completed their mandatory training (particularly safeguarding level three) and the trust's target had not been met in all cases. The service had plans in place to address this.

The closed circuit camera system (CCTV) in the maternity block was not appropriate. There was no CCTV at all ward entrances; there were cameras at the entrance to the building. The service was taking action to address this.

Women shared a waiting room for gynaecology and maternity appointments, which was not sensitive to the reasons why women attended their appointments. The service had a plan to address this.

The Supervisor of Midwives (SoM) ratio was worse than the recommendation of 1:15. The service had agreed a local arrangement for enabling the Supervisors of Midwives extra time allocation for work related to Supervision.

Whilst the gynaecology service did have a performance dashboard which monitored a range of outcomes, the newly established gynaecology governance group had not set the parameters for monitoring performance at the time of the inspection. The service was in the process of implementing clear performance measures for the service.

We saw that reporting incidents to the National Reporting and Learning System (NRLS) was not always

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timely. However the trust were aware of the issue and improvements had been made as part of the overarching trust wide risk and governance improvement plan.

Information leaflets provided by the termination of pregnancy service were only available in English which did not reflect the diversity of the local population.

## Are maternity and gynaecology services safe?

Good



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

- Incidents were reported and were investigated in a timely manner and there was good evidence of shared learning where full investigations had taken place.
- Service areas were visibly clean during the inspection.
- Equipment was generally checked regularly and well maintained.
- Medicines were stored and handled safely.
- Records were stored securely and completed in accordance with trust policy.
- Safeguarding vulnerable adults, children and young people was a priority for the service. We saw staff responded appropriately to signs or allegations of abuse and worked effectively with others to implement protection plans.
- There was active engagement in local safeguarding procedures and we saw effective work with other relevant organisations during the inspection.
- At the time of inspection, staffing in maternity and gynaecology services was appropriate to meet the needs of the patients.
- There was an escalation process in place, which outlined action to be taken in the event of high levels of acuity and/or staffing shortages.
- There were effective systems in place for assessing and responding to patient risk.

However:

- The closed circuit camera system (CCTV) in the maternity block was not appropriate. There was no CCTV at all ward entrances. There were cameras at the entrance to the building. The service was taking action to address this; they had plans in place to put cameras at each ward entrance enhancing visibility of the security team.
- Not all clinical staff had attended safeguarding training that was relevant to their role at the time of inspection. The service had plans in place to address this.

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- We saw that reporting incidents to the National Reporting and Learning System (NRLS) was not always timely. However the service was aware of this issue and were working to address the situation as part of the trust wide risk and governance improvement plan.
- Medical staff in maternity and gynaecology had not met the trust's internal target for mandatory training and infection control training. Plans were in place to address this.

## Incidents

- Clinical staff we spoke with were aware of the reporting process for incidents, near misses and never events. The trust used an electronic incident reporting tool to report incidents. The staff we spoke with were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so.
- Maternity and gynaecology services had a clinical risk management policy and framework which identified the management arrangements and processes for the identification, assessment, treatment and monitoring of clinical risks. The framework identified clinical events (triggers for investigation) within maternity services and outlined the procedure to be followed in such cases. The triggers for investigation included examples such as an intrapartum stillbirth, maternal death, an unrecognised third degree tear where failure to repair may have resulted in harm or uterine rupture. We saw guidance for management of clinical risk which included implementation of immediate safety measures, support for parents/families involved, preservation of evidence, collection and copying of statements of staff involved in the incident, investigation including a full root cause analysis and written report and dissemination of feedback.
- There had been one never event between October 2014 and September 2015. The never event was classified as 'wrong route administration of medication' where an oral medication was drawn up into an injection syringe and inadvertently injected via intravenous route. Never events are serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- During the inspection, we reviewed the root cause analysis investigation report and saw evidence of learning from this event, which had been embedded within the service and the hospital. The trust had mitigated future risk by recommending that all oral medications were to be administered in oral syringes or graduated medicines cups. Teaching and process changes were supported by pharmacy. The trust had informed all staff of lessons learnt in a variety of methods such as screensavers on trust computers and via the trust wide patient safety newsletter.
- There were nine serious incidents (SI's) reported to the strategic executive information system (STEIS) in the twelve month period covering December 2014 to November 2015. This was that this was in line with national expectations for a unit of its size and with the complexity of patient group. We saw learning from these events embedded within practice.
- Two of the SIs were classified as maternity/obstetric incident meeting SI criteria: baby only. Two were classified as a diagnostic incident including delay meeting SI criteria. Two were classified as a medication incident meeting SI criteria. One was classified as maternity/obstetric incident meeting SI criteria: mother. Two were classified as screening issues meeting SI criteria.
- The most incidents were reported in July 2015 with three incidents reported; however, there were no common themes to these incidents. Serious Incidents (SIs) associated with maternity included unexpected admissions to the neonatal intensive care unit (NICU). Incidents were classified following guidance provided by the clinical risk management framework and had been classified correctly. Root cause analysis investigations were carried out in set time scales and evidenced that the service had implemented immediate safety measures.
- One SI had resulted in death, where a confirmed intrauterine (within the uterus) death had occurred following diagnosed Obstetric Cholestasis. (Obstetric cholestasis is a rare complication of pregnancy. A build-up of bile acids in the bloodstream causes a persistent itch in the last third of pregnancy. There may be a small increased risk of complications of pregnancy associated with this condition, but the evidence is not conclusive.)

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- There were 1,308 incidents recorded in the eleven-month period January 2015 until December 2015, an average of 119 per month. The highest number of incidents occurred in May 2015, with 164 incidents. 1,287 of the incidents (98%) resulted in no harm.
- We saw that where necessary investigations including root cause analyses were carried out. We saw learning from these events embedded within practice. Senior staff held regular meetings to identify where trends had occurred and to put systems in place to prevent similar occurrences. They also monitored whether the required actions had been addressed.
- The minutes of monthly governance meetings informed us that the actions taken and lessons learnt were of an appropriate standard to prevent recurrence.
- We spoke with staff about learning lessons from incidents. All of the staff we spoke with on the maternity unit or gynaecology ward spoke about the process and told us they received direct feedback relating to incidents they had been involved with. Staff also told us that they received updates about other incidents, which had occurred. We were told that they were kept informed about these through the handover, as well as regular bulletins. Information shared included information about incidents, which had occurred, lessons learned as well as changes made as a result. We asked staff about specific serious incidents, which had occurred during the previous year both on the gynaecology ward as well as in maternity. Staff were able to provide a detailed account of lessons learned in their own unit.
- We saw that 27% of incidents (356) were reported to the National Reporting and Learning System (NRLS), within 30 days of the incident. 98% (1282) were reported within 60 days. Between June 2015 and August 2015, the percentage of incidents reported within 30 days increased, however this percentage decreased again from September 2015 onwards. The service was aware of the issue and work had been carried out to improve the situation. In November and December 2015, all incidents (100%) were uploaded within 30 days from the date of the incident.
- The trust held monthly internal perinatal mortality and morbidity meetings (PMM). The membership of the PMM comprised of the neonatal medical team, neonatal senior nursing management team, obstetric team,

midwifery management team, antenatal sonographers, head of midwifery and, obstetrics risk manager. The trust also held a quarterly joint meeting with the inclusion of the geneticist and perinatal pathologist.

- The group aimed to ensure that the priority of the meetings was to support a culture of learning to help improve patient/parent feedback. This included updates on cases jointly seen as well as providing quality assurance through internal case reviews and audits. Review of the minutes confirmed an outline of each case was provided and learning points identified.

## Duty of Candour

- 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 described a working environment whereby they would investigate and discuss any duty of candour issues with the patient and their family and/or representative and an apology given whether or not there had been any harm.
- Staff we spoke with were aware of their responsibilities with regard to the duty of candour. Midwives and doctors were able to describe how complaints and concerns were being managed and kept families informed about how their concerns and complaints were being dealt with. Outcomes were shared.
- Staff were able to provide examples of when an incident had occurred and how they had informed the patient and their relatives of the incident made an apology and explained how the trust had responded to the incident.

## Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecology (RCOG) in October 2014. This is a system of reporting on harm-free care that covers a range of areas including admissions to neonatal units, perineal and abdominal trauma (complications following surgery), post-partum haemorrhage (excessive blood loss following delivery), infections, psychological safety, separation from baby and APGAR scoring (The Apgar score is a simple assessment of how a baby is doing at birth, which helps

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determine whether the new born baby is ready to meet the world without additional medical assistance). Each clinical area in maternity and gynaecology collected information as part of its safety monitoring.

- The hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre as required. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from the gynaecology ward as well as each of the units and wards on maternity. It covered hospital-acquired (new) pressure ulcers classified as grades three and four (the most serious pressure ulcers); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). Between December 2014 and December 2015, one fall with harm was reported in the Patient Safety Thermometer. The trust reported no pressure ulcers or catheter associated new urinary tract infections. No trends over time in prevalence rates of pressure ulcers, falls or catheter UTIs could be noted, as there were very small numbers of incidences reported.
- The service took part in the national maternity dashboard, which measured outcomes. The dashboard data was compared with safety-related targets on a monthly basis. The indicators used included the percentage of caesarean sections and other assisted deliveries (where forceps or a suction cup called ventouse were 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.

## Cleanliness, infection control and hygiene

- We found the gynaecology wards; delivery suite, midwife-led birth unit (MLBU) and outpatient environments were visibly clean and tidy during our inspection.
- There was a service level agreement in place between the trust and the contractors who cleaned patient and public areas, which set out the daily and weekly cleaning schedules. Each patient area displayed the up to date cleaning schedule. Nursing staff were responsible for cleaning equipment and we saw that stickers were placed on items of equipment stating when they had last been cleaned.
- Hand gel was available at each doorway on the wards.
- Side rooms were available in each ward area, which could be used to admit someone who may have an infection as required.
- Staff had access to infection control policies and procedures. Staff we spoke with told us and we saw that they were accessible on the hospital intranet.
- Patients we spoke with said they were satisfied with the standards of hygiene. They told us that they found patient areas to be clean and their bed sheets were changed at least daily. On the occasion that their beds required more frequent change, this was done without any issue.
- Staff wore clean uniforms with arms 'bare below the elbow'. We saw staff wearing the correct personal protective equipment (PPE) such as gloves and aprons as per trust protocol and we observed PPE to be throughout the ward areas.
- As at 30 November 2015, 86.4% of nursing and midwifery staff in maternity and gynaecology had up to date training in infection control and 77.5% of medical staff had up to date training. The trust's internal target for this training was 80%.
- Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium-difficile (C.Difficile) Healthcare-associated infection (HCAI) were reported to the individual wards, divisions and via the divisional infection protection and control report to the Clinical Operations Board. All HCAI were thoroughly investigated through root cause analysis (RCA) investigations to identify any failures in practice or trends. The Infection Control Team (ICT) reviewed all RCAs and shared learning within the organisation and local health partners.
- There were no newly identified hospital acquired C.Difficile positive patients on the maternity and gynaecology wards within the time period October 2013 and September 2015. There were seven newly identified hospital acquired MRSA positive patients on the maternity wards within the time period of October 2013 and September 2015. There were three cases identified between April 2015 and September 2015. There was one newly identified hospital acquired MRSA positive patient on the gynaecology wards within the time period October 2013 and September 2015, and this occurred in the time period between July 2015 and September 2015. All cases were considered hospital acquired MRSA

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colonisation identified via routine testing. The trust told us they took reasonable ownership of identified MRSA colonisations. There were no trends, clusters or concerns identified requiring further action.

- Infection prevention and control audits were being carried out. Trust wide audits of infection prevention standards were undertaken by the ICT using an adapted Infection Prevention Society (IPS) audit tool, which provided detailed review of ward areas and practice. They looked at patient environment, dress code, hand hygiene, utility rooms, storage domestic room, toilets, bathrooms, kitchen, linen storage, equipment storage and cleanliness, waste, PPE, standard precaution isolation, urinary catheter usage and venous cannula management. The ICT provided immediate feedback to the nurse in charge and a written report with RAG rating was sent (within 48hrs) to the divisional matron, clinical director, general manager and ward sister with a view to producing an immediate action plan which was then reviewed and RAG rating adjusted accordingly. (A rag rating is a visual cue using red amber green rating system or traffic light rating system).
- We saw the hand hygiene compliance for ward 33 and ward 34 were 100% for September 2015. Any scores less than 80% were escalated to management. Information for the wards provided by the trust showed that neither ward had been escalated for non-compliance between April 2015 and September 2015 but that immediate action was now being taken to improve this hand hygiene compliance.
- Women were offered flu and whooping cough vaccine in pregnancy.

## Environment and equipment

- 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.
- Cardiotocography (CTG) machines were available and were also checked daily.
- The anaesthetic machine in theatres was checked daily as well as before every surgical case.
- We could not see documented evidence that the post-partum haemorrhage trolley weekly checks were

being done on ward 32. We found that the recordings for September 2015, October 2015 and November 2015 recordings were not available. We raised this with the ward manager at the time of inspection who advised she would take immediate action to ensure all checks are recorded.

- We spoke with staff from various departments within the maternity and gynaecology services. They told us they had adequate supplies of medical equipment.
- We saw folders on the wards, which provided evidence of a maintenance schedule and asset list of necessary equipment including next service dates.
- We saw stickers on equipment with service dates on which provided assurance that the equipment had been PAT tested, regularly serviced and conformed to relevant safety standards. Portable appliance testing or PAT Testing is the process of checking electrical appliances for safety through a series of visual inspections and electronic tests.
- We observed pre-operative and post-operative checks in theatre and saw that staff checked and counted all equipment before and after the procedures.
- The areas where women received their care were noted to be suitably laid out and provided privacy for times when discussions were held in supporting them with their care needs.
- The delivery suite, MLBU, postnatal, antenatal and gynaecology wards had restricted access. Access was by a swipe card or buzzers to request access by staff. The babies were placed in alarmed cots that alerted to unauthorised removal from the cot.
- It was noted that the divisional manager had documented a risk on the register in June 2015 relating to the inadequacy of the CCTV system in maternity. Since that date, the cameras for the maternity front entrance had been linked to the security control room and the security manager had completed a business case and submitted it to the board to support implementation of CCTV cameras at ward entrances. At the time of inspection the cameras were not in place and we were not given a date for installation.
- Some of the areas in the delivery suite were in need of investment with some maintenance issues i.e. damaged floors, walls. The current facilities at the hospital pre-dated the most recent guidance. The trust estates department stated that the existing buildings presented a number of challenges due to age and condition.

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- Various programmes of work had been completed over time to maintain the internal environment. However, it had been recognised that replacement facilities were required not only to address matters of patient experience but also to create additional capacity in response to growing demands for the service.
- The MLBU had been refurbished in the last two years and ward environment was in a good condition.
- The service had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage

## Medicines

- We observed medication was stored appropriately and medication, including controlled drugs, had been recorded as administered in accordance with requirements.
- There was access to emergency medicines, such as those used for allergic reactions and for treating low blood sugars to prevent further complications.
- 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 told us that drug errors were reported via the incident reporting system and were reviewed under the normal incident process. We saw evidence of this on the incident forms.
- Controlled drugs were stored correctly within a wall mounted locked cupboard and staff regularly checked the numbers of each drug against the recordings. These checks were recorded and signed by two staff.
- During pharmacy opening hours, there was a fast track system in place to dispense drugs to maternity, which allowed priority dispensing through pharmacy if requested.
- Audits were carried out and any themes arising were cascaded to relevant staff teams.

## Records

- We reviewed six sets of care records in various areas of the maternity and gynaecology services. These had been completed with relevant current and previous clinical information. There was detailed information where explanations had been given. All recordings had been dated and signed.

- 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.

## Safeguarding

- There was a designated safeguarding lead and a safeguarding team who dealt specifically with patients assessed as being at risk of harm and protected babies before and after birth. The safeguarding team provided additional support for women during their pregnancy and hospital stay. We saw evidence of the good working relationship between the local authority and police in practice during our inspection.
- Community midwives assessed the vulnerability of women during the antenatal and postnatal periods. All 'booking appointments' were carried out at the women's home. Safeguard alerts and areas of concern were recorded on the maternity system. The safeguarding midwife also undertook checks of all records for women seen at the booking appointments. Members of the safeguarding team were available to provide advice and to take appropriate action within the community and the hospital.
- Safeguarding training and refresher training was part of the mandatory annual workshop. Staff were also encouraged to access e-learning courses. Not all clinical staff had attended safeguarding training that was relevant to their role. The training data confirmed that as of 30th November 2015, 82% of maternity and gynaecology nursing and midwifery staff had up to date

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training in adult safeguarding and 99% had up to date training in level two safeguarding children. 34% of maternity and gynaecology nursing and midwifery staff had up to date training in level three safeguarding children which was below the trust target of 80%.

- 68% of medical staff had up to date training in adult safeguarding and 70% had up to date safeguarding children level three training which was below the trust's target of 80%. The trust told us they had established sufficient capacity for training to ensure all level 3 training would be completed by June 2016.
- 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.
- We saw that there was no safeguarding pro-forma in the consultation section within the termination of pregnancy service (TOP service) notes and therefore we were not assured that safeguarding concerns had been considered for each patient attending the service. We raised this with the trust who took immediate action.
- However, staff working in the TOP service) were able to give examples of when they had raised safeguarding concerns for both children and adults and how they would access support and help if needed. We saw evidence of a referral for concerns regarding domestic abuse in a patient's notes.

## Mandatory training

- Over 80% of maternity and gynaecology nursing and midwifery staff had up to date training in all the mandatory training modules, except for conflict resolution (only 34% of nursing/midwifery staff had completed this module).
- The service met the trust's 80% target for medical staff completing mandatory training for fire safety. We saw plans were in place to address this concern with training dates arranged.
- All newly appointed midwives attended a tailored induction course. The course included mandatory training courses such as, PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working. It also

included cardiotocography (CTG) training (CTG is done to see if the baby's heart beats at a normal rate and variability), K2 training (Interactive computer-based training and certification in foetal monitoring to improve core knowledge and skills.), infant feeding, diabetes, and human immunodeficiency virus (HIV).

- PROMPT training, CTG training, K2 training and the obstetrics study day were repeated annually. 87% of midwives, 76% of maternity care assistants and 76% junior doctors were up to date with PROMPT training. 100% of the consultants were trainers on the PROMPT course. 84% of midwives were up to date with the obstetric study day (including 1hr CTG lecture). The service told us there had been a CTG Masterclass in July 2015 which was provided by an expert professor in CTG monitoring (7.5 hours of training); 40 midwives had attended and 79% of medical staff including consultant obstetricians. A masterclass date had been booked for July 2016 and these were to be repeated annually.
- The service ran a K2 (CTG training package) which had become mandatory from April 2015. 44% midwives had attended (although it should be noted that 87% of acute and community midwives had received CTG training through PROMPT and 100% of acute hospital based staff have received CTG training.) 78% of medical staff had attended the training.
- HIV and infant feeding study days were repeated every three years.

## Assessing and responding to patient risk

- Women from 16 weeks gestation onwards with concerns about their pregnancy such as pain, vaginal bleeding, women who suspected that they had broken their waters or those that suspected that they were in early labour were seen in the maternity triage unit which was staffed by midwives and healthcare workers.
- There was a designated 11-bed triage area where women with urgent health issues could be reviewed and assessed. Women were provided with the telephone number for the unit and could access it directly if they had any concerns. All women that accessed the triage unit were triaged in line with a traffic light system, according to clinical assessment using Red, Amber and Green (RAG) ratings. Any delays of 30 minutes between presentation and triage were to be escalated to the midwife co-ordinator, and the senior obstetrician.
- The service had started to monitor the effectiveness of the triage service. In December 2015 the majority of

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women (77%) were seen within 15 minutes of arrival. Information collected in January 2016 showed 63% of admission sheets did not have the time the woman was seen recorded so they were unable to effectively report on triage times. The service was taking urgent action to address this concern.

- Records we viewed had pre-operative checklists, and venous thromboembolism (VTE) assessments had been completed and assessed at each appointment, on admission in labour or for elective delivery and immediately postnatally before discharge from the delivery suite. The trust used the modified obstetric early warning score (MOEWS) and audited the use of this tool on a monthly basis. The audit lead midwife led the audit in October 2015. The service had reviewed 43 MOEWS over two days on both the antenatal and postnatal wards. They had looked at 17 antenatal and 26 postnatal records. In total 37 (86%) MOEWS were 100% complete and actioned. Findings were shared with all midwives and doctors via email and the results were put on the delivery suite newsletter. The results were sent to supervisor of midwives (SoM) so that the results could be discussed at the SoM annual review with midwives.
- 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 Maternity unit had started to audit the service against the World Health Organisation (WHO) 'safer surgery safety checklist' from September 2015 by randomly selecting cases of woman that had delivered in theatre or needed to return to theatre. The results were not yet available at the time of inspection.
- Women who had a general anaesthetic for a caesarean section remained in theatre until they were fit for discharge from the recovery area. 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.

- For minor gynaecology cases, recovery room staff were auditing 20 cases at random per month to ensure compliance that the five steps to safer surgery checklist was present in the patient's notes and for completeness. All sections of the form were to be completed and the required signature panels were signed off by all members of the multi-disciplinary team (Anaesthetist, Anaesthetic Practitioner, Surgeon, Circulating Practitioner and Scrub Practitioner) For September 2015 and October 2015, the audit had been completed and showed 100% compliance for each month. Findings from this audit were fed back to the theatre team, the obstetric doctors and to the PROMPT Team who encouraged the use of these forms for all cases in theatre.
- 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 five 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. We saw a referral being responded to by the tissue viability nurse during our inspection.

## Midwifery and nursing staffing

- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection. Staff rotas demonstrated that where there were reduced staffing levels, plans were in place to address the risk to care delivery.
- All areas were reporting planned and actual staffing levels using the trust's safe staffing protocols and the daily shift cover of midwives, nurses and health care assistants was on display in each area we visited.

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- We reviewed the rotas for November 2015, December 2015 and January 2016 for the maternity and gynaecology wards. We could see that staffing had been well-managed to meet the complexity and needs of the women within the service.
- Nursing staff within gynaecology had a vacancy of by 1.93% whole time equivalent (WTE).
- The gynaecology service reported that agency use was at 1.15%WTE. We saw that agency staff received a robust induction to the ward on their first time they worked within the service.
- We reviewed the rotas for the gynaecology ward and we saw the average fill rate for nursing staff for days was 98% and for nights was 96%. The average fill rate for care staff for days was 98% and nights was 97%.
- There had been no incidents related to staffing in the past three months on either the maternity wards or the gynaecology ward.
- There was a staff escalation plan in place to address staffing issues. There were three operational staffing meetings each day chaired by the operational matron/ Chief Nurse or Deputy Chief Nurse. Matrons from each division discussed the staffing shortfalls and moved staff accordingly to meet the needs, demands and acuity of the women within the service. A decision to use agency nursing staff was only made once all other options have been explored) Additional shifts required (i.e. providing one to one support for a patient) and unfilled shift hours were recorded. Each Matron provided the risk rating for staffing (red/amber/green) for their division. A trust wide risk rating was then determined and this information was provided to the twice daily bed meetings to provide a workforce status for the organisation. Weekly meetings occurred with the matrons to review the utilisation of staff and expenditure per ward.
- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, is one whole time equivalent (WTE) midwife to 28 births (1:28). This is a system for ensuring sufficient staff availability to provide safe care. Data from the hospital informed us that the ratio of all midwifery staff to births was 1:26 including bank staff in May 2015 compared to 1:27 nationally. During the inspection, we were informed that the midwife to birth ratio was 1:29.
- The trust with the Head of Midwifery carried out six monthly establishment reviews. In addition to this, the trust commissioned a review using Birth Rate Plus (a national tool available for calculating midwifery staffing levels by working with individual trusts to understand their activity, case mix, demographics to calculate an individual ratio of clinical midwives to births for maternity services). The HOM had submitted a business case for the February 2016 divisional board meeting to request to increase the staffing in maternity to 1:28 following the most recent review taking into account the increase in women with complex conditions such as diabetes and mental health. Additionally the trust had appointed speciality midwives for diabetes and mental health and a consultant midwife in the past 12 months to support normalisation and natural birth.
- The service told us that they were able to provide 1:1 support for 95% of mothers in established labour, until delivery of their baby. The dashboard for January reported that 100% of women were provided 1:1 support, but on occasions, this relied on, moving staff from the community team. We spoke with a range of staff of various grades in the maternity and gynaecology service. They felt there were sufficient staff and during busy periods, they all worked together, to ensure patient's needs were met appropriately.
- The trust had introduced a supernumerary status band seven midwife for the delivery suite at night. We were told the increase in establishment had resulted in an increase of vacancies. The overall vacancy rate for maternity was 13%. The vacancies had been filled by bank staff while the recruitment process was undertaken. Agency midwives were not used in the service. The nursing and midwifery recruitment situation was identified as a priority in the September 2015 divisional performance review. We saw that the HOM had reviewed the maternity staffing in January and had submitted a business case to the executive board in January 2016 to increase the midwife establishment by 6.22WTE. We were unable to report on the outcome at the time of the inspection.
- The specialist midwives such as the practice development midwife, consultant midwife worked in the clinical areas during peak periods. This influenced the ratio of midwives to the number of births.
- The hospital employed midwifery managers who were supernumerary to ensure the smooth running of the labour ward and appropriate allocation of midwives to women. They assessed the staffing levels three times a day against the anticipated workloads and when

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necessary allocated more bank midwives to work in the labour ward. The staffing rotas for November 2015, December 2015 and January 2016 that we reviewed confirmed that changes had been made to meet anticipated demand in staff. The midwifery manager was an on call role that covered 24 hours a day seven days a week. They were point of escalation for staffing concerns and would take appropriate action as needed.

- We were told staff were on occasions moved to work on other areas of maternity and in particular from the antenatal ward as well as community midwives who were on-call.
- Two of the mothers we spoke with told us on occasions the post-natal ward felt busy and this had impacted on the time staff were able to spend with each mother and her baby.
- We observed a lunchtime handover on the gynaecology ward, which was detailed and effective. Nurses were allocated bays on the ward and staff were given information on the current needs of the patient.
- We observed a midwifery handover, which was detailed and effective. Each woman on the unit was discussed by the shift leader and midwives were allocated to women for their shift.

## Medical staffing

- 44% of medical staff were consultants which was above the England average of 35%. The percentage of middle grade doctors was at 3% which was below the England average of 8%. Middle grade doctors have at least three years' experience at senior house officer level or a higher grade within their chosen speciality. 45% were registrar group, which is below the England average of 50% and 8% were classified as junior grade, which was slightly above the England average of 7%.
- During inspection we saw medical cover had been managed to meet the complexity and needs of the women within the service.
- According to trust information, medical staff within Obstetrics and Gynaecology was at full establishment as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) standards.
- The service informed us that the average number of hours per week of consultant cover on the labour ward between January 2014 and June 2015 was 105 hours per week, for all months in the period. This had exceeded the 60 hours recommended by the (RCOG) Safer Childbirth guidelines.

- An audit of consultant cover provided in August 2015 confirmed that 122 hours per week was achieved between February 2015 and July 2015. The trust told us and staff we spoke with, confirmed between Monday to Thursday the obstetric consultants provided on-site cover (Consultant presence) for 24 hours on each of these days. Gynaecology consultants provided cover from 8:30am until 8:30pm on site. On Fridays, the obstetric consultants and gynaecology consultants were on site between 8:30am and 8:30pm. On Saturdays and Sundays, there was obstetric cover between 8:30am and 3:30pm and gynaecology cover from 9:00am-11:00am. Both were flexible to stay on longer as the service demanded.
- On-call arrangements were in place and worked well. Consultants covered the on-calls from home from 8:30pm until morning for both obstetrics and gynaecology except for Wednesdays and Thursdays obstetrics cover when the duty consultant was resident at night. Staff we spoke with did not have concerns about contacting the on-call consultant.
- The rest of the cover and night cover when consultants were not on site was provided by a team of two middle grades and one junior grade doctor all with varying experience. There was a senior experienced middle grade doctor in the team. All aspects of service delivery from 8am to 5pm were supported by a team of junior and middle grade doctors that covered all areas of obstetrics and gynaecology. This ranged from clinics, wards and theatres.
- There was also a dedicated consultant ward round every day of the week and we observed a medical handover and found that this was effective and that relevant information was communicated clearly.
- There had been no reported incidents, which related to a lack of senior medical staff on duty.
- Midwives, nurses and junior doctors we spoke with told us that senior medical staff responded when their presence was requested.

## Major incident awareness and training

- The trust had contingency plans for maternity services that had been ratified in January 2014. These plans covered staffing, beds shortage, closure of the unit, mobile phone failure, abandoned baby, abducted baby and lift failure. Staff we spoke with throughout the service were aware of these plans.

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- There were policies available to staff on the hospital intranet for dealing with major incidents. Staff showed an understanding of the policies.
- Staff were aware of fire safety precautions and evacuation plans.

## Are maternity and gynaecology services effective?

Good



Overall we rated the service as good for effectiveness because:

- Women's care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation.
- Elective caesarean delivery, low forceps cephalic delivery, forceps delivery and ventouse (vacuum) delivery was in line with the England average. Emergency caesarean delivery was slightly above the England average and normal (non-assisted delivery) was slightly below the England average.
- A range of audits were carried out concerning care and treatment to identify where improvements could be made to staff practices.
- We saw that women received pain relief as required.
- Access to medical support was available seven days a week throughout the service.
- Adequate arrangements were in place to ensure women and their babies received nutrition and hydration.
- The maternity service held UNICEF stage two baby friendly accreditation.
- There were systems in place for staff to enable them to keep pace with changes and developments elsewhere in the trust and to access guides, policies and procedures to assist in their specific role.
- Information needed to deliver effective care and treatment such as care and risk assessments, care plans, case notes and test results was accessible.
- The hospital had set procedures in place for assessing patient's mental capacity, whether they came into the hospital as an emergency or a planned admission. Staff we spoke with talked confidently about mental capacity assessments within the remit of their role.
- Completion of certificate for terminations was in line with the legislation.

However, we found that:

- The service had agreed a local arrangement for enabling the supervisors of midwives extra time allocation for work related to supervision. The ratio in December 2015 was 1:21, which was above the recommendation of 1:15.
- Not all staff had an up to date appraisal.
- Whilst the gynaecology service did have a performance dashboard which monitored a range of outcomes, the newly established gynaecology governance group had not set the parameters. The service was not able to identify areas of compliance that needed addressing.

## Evidence-based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as, the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines (2007).
- Antenatal, intrapartum and postnatal care was provided in line with NICE quality standards. Policies we saw within the service reflected these guidelines. 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 hospital was following RCOG guidelines on antenatal tests for women at low-risk.
- The service actively participated in national audits including the National Screening Committee antenatal and new born screening audit. We saw a copy of the antenatal and new-born screening annual report for 2014-2015. 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.
- We saw there was adherence to trust policies and procedures across the department. Such as adherence to infection control policies
- Care plans for patients who had gestational diabetes were developed and were in place.
- Midwives who worked in the midwife-led birthing unit followed NICE guidance and the Royal College of Midwives (RCM) guidelines.
- There was a clearly defined audit plan entitled Women's and Children's Services: Obstetrics and Gynaecology for

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2015/16. The service told us there was a programme in place for women's services to ensure they were continuously improving their patient care, which was informed by national guidance, patterns of incidents and clinical data outcomes. For example, postnatal re-admissions and third/fourth degree tears were being audited.

- Ten audits were undertaken each month and areas for improvement were included in the maternity action plan. Results were discussed at the Nursing and Midwifery Quality and Performance Meetings. These were chaired by the Chief Nurse. The 10 audits selected for review during 2014/15 were communication, essential rounding, observation, continence, falls, fluid balance, nutrition, oxygen, pain management, pressure area care and manual handling.
- We reviewed a sample of audits and found the aims, objectives, results and conclusions were clearly defined.
- The consultant midwife told us they used the message of the week format to promote learning of evidence-based practice. We saw the message of the week discussed at the handover we attended. We were told by staff the same message was reiterated at each handover during a seven-day period and staff told us they found this very helpful in ensuring they learned from the information being shared.
- The trust contributed data to the National Neonatal Audit Programme (NNAP) and met three of the five standards for 2013. They did not meet the standard for the proportion of babies with a gestational age of 32+0 weeks or 1501g at birth undergoing 1st Retinopathy of Prematurity (ROP) screening. The service achieved 99% compared to a standard of 100%. Additionally the trust did not achieve the standard related to documented consultations with parents within 24 hours of admission achieving 96% compared with a national standard of 100%.
- Three out of five questions in the national neonatal audit met or achieved above the NNAP standard/benchmark. These were:
  - Do all babies at 28+6 weeks gestation have their temperature taken within the first hour after birth? The NNAP standard was 98-100% The Hospital achieved 100%.
  - Are all mothers who deliver babies between 24+0 and 34+6 weeks gestation given any dose of antenatal steroids? The NNAP was standard 85%. The hospital achieved 89%.
  - What proportion of babies 33+0 weeks gestation at birth are receiving any of their mother's milk when discharged from a neonatal unit? The NNAP standard was 58% The hospital achieved 68%.
- The Kirkup report was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made recommendations for the trust and wider NHS, aimed at ensuring that any failings in a service were properly recognised and acted upon. We saw documentary evidence the service had monitored its performance against the recommendations of the report. We saw evidence of a formal action plan, which was monitored through the main maternity action plan. Staff we spoke with on the maternity were aware of the Kirkup report.
- 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.
- We saw documentary evidence that 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
- We saw documentary evidence that contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after a termination. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- Women undergoing medical abortion were asked to ensure that a pregnancy test was completed after two weeks post procedure to ensure that the procedure had been successful.

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- A discharge letter was given to women who had undergone TOP providing sufficient information to enable other practitioners to manage complications.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4.
- The TOP service carried out an audit in November 2015 on the use of contraception pre- and post-termination of pregnancy in response to the published research that showed that 57% of unwanted pregnancies occurred whilst women were using contraception, mostly short-acting methods such as condoms and the oral contraceptive pill. The research showed that User-independent long-acting reversible contraception (LARC), such as implants, intra-uterine contraceptive devices (IUCD), or injections, provided a reliable means to reduce the incidence of unwanted pregnancies and requests for termination.
- The audit was to identify the methods of contraception used by women attending for TOP and what pathways were to be followed. It included whether a discussion about contraception was had prior to discharge and the contraceptive method used post-TOP. The findings of pre-TOP contraceptive use confirmed that no woman who presented with an unwanted pregnancy had been using a user-independent LARC method. 55% of women took up a LARC post-TOP at Luton Dunstable Hospital, which was less than the women who received a LARC post-TOP from a private provider (63%). The findings of the audit were presented to the obstetrics and gynaecology department clinical governance meeting.

## Pain relief

- Pain relief was available for maternity patients and included Entonox (gas and air), pethidine and epidural anaesthesia.
- Use of the birthing pool was offered as a method of pain relief. One was available in the midwife-led birthing unit. Women were encouraged to use this facility.
- All of the women we spoke with on the maternity and gynaecology wards told us they had received pain relief as required.
- Women were routinely offered pain relief during medical abortion. We saw that the TOP service used prescription charts that were prepopulated with medication and dosage this included as required pain relief medication

which was tailored to the patient's needs by the consultant at the time of the treatment. We reviewed five medicine charts, which provided evidence of this practice.

- The staff we spoke with told us there were no issues in obtaining pain relief or other medication for patients and women.

## Nutrition and hydration

- Women told us they received support and advice for breastfeeding their babies. The uptake of breast-feeding was monitored quarterly. For September 2015 to January 2016, breastfeeding at the point of discharge was at 74% which was comparable to the national statistics of 77%.
- The maternity service held stage two baby friendly accreditation. The baby friendly initiative awards are based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways, which will support optimum health and development. Facilities implement the standards in stages over a number of years. At each stage, they are externally assessed by UNICEF UK. When all the stages are passed, they are accredited as Baby Friendly. Award tables are kept to let the public know how facilities are progressing.
- The service told us that from 1 April 2015 infant formula was not available to mothers who had made the decision not to breast feed their baby. Mothers were informed they would need to bring in with them a supply of bottles of 'ready to feed' 1st stage baby milk and a supply of teats.
- The service informed us in the cases where a mother could not feed, was too ill to feed or midwives were concerned about the baby's weight, formula milk would be provided.

## Patient outcomes

- The maternity and gynaecology departments each maintained a quality and performance dashboard, which reported on activity and clinical outcomes.

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- In maternity, performance was monitored for a range of outcomes including normal vaginal deliveries, instrumental deliveries, caesarean sections, unexpected admissions to intensive care and high dependency unit as well as the number of third degree tears.
- Proportions of deliveries by recorded delivery method between June 2014 to July 2015 revealed elective caesarean delivery was 11%, which was in line with the England average. Emergency caesarean delivery was at 17% slightly above the England average of 15%. Low forceps cephalic delivery was 3% which was in line with the England average, forceps delivery was at 4% which was in line with the England average, ventouse (vacuum) delivery was at 7% in line with the England average and normal (non-assisted delivery) was at 58% which was slightly below the England average of 60%.
- Third degree tears were monitored by the service. The service reported 1% in August 2015 and 2.24% in September 2015 which were scored as red on the trust maternity dashboard. We saw training was provided to midwives to mitigate future risk. The rate reduced to 1.7% in October 2015 but increased to 2% in November and 2.18% in December 2015. We were told that the service continued to review the situation.
- The trust reported on the number of PPH over 2.5 Litres (a PPH over 2.5 Litres is termed as massive postpartum haemorrhage). The service reported 0.66% (three) in September 2015 and 0.21% (one) in October 2015; there were none reported in November and December 2015. All reported were below the trust's threshold of six.
- Still birth rates for the trust were 4.8 per 1000 births which was slightly above the England average. The Office of National Statistics report published in March 2015 indicated that in England the stillbirth rate is 4.7 per 1000 births. The service had actions in place to monitor and address any issues relating to the still births such as immediate multidisciplinary case review when a still birth had occurred to ensure early identification of issues and subsequent learning and a multidisciplinary case review meeting every six weeks (pursuing perfection panel) where all cases are reviewed again for any themes and further learning. This group was established to review and reduce the number of avoidable still births.
- One mother was admitted to the high dependency unit and two babies admitted to NICU during the period August 2015 to December 2015, which was not flagged as a concern, as it was under the hospital set monthly risk threshold of three.
- We reviewed the gynaecology dashboard for January to October 2015. Performance was monitored for a range of outcomes including routine admissions, emergency admissions overnight bed occupancy, readmission within four weeks, readmissions within 48 hours for routine theatre cases and hysteroscopy in theatre outpatient. Data was provided for all the above outcomes.
- We were told by the service the newly established gynaecology governance group was in the process setting the parameters for the dashboard, which have yet to be agreed. The key areas the service was in the process of review was 14 hour standard for consultant review achievement. The results of the review was reported to consultants monthly and raised at the directorate meetings to improve compliance. The service told us that they had identified that recording clearly in the notes was an issue and reminders have been issued. This is subject to on-going monitoring.
- The service had identified that there was an increase in the need for outpatient hysteroscopy. They had identified an action plan to address this issue. The Directorate had a hysteroscopy nurse in training and once training was completed and signed off as competent, will run their own clinic. This was planned to be in place by the autumn 2016. Similarly, to address the need to increase provision of outpatient cystoscopy service to manage increased demand, an extra cystoscopy clinic was to start in March 2016.
- The TOP service were carrying out a formal audit of failure rate for termination of pregnancies. Whilst some staff we spoke within gynaecology service were not able to provide assurance that the service was carrying out an audit, the trust were able to provide evidence that a snap shot audit was carried out in January 2016 that covered the time period October 2015 to January 2016. Of the terminations completed, the failure rate was noted at 6%, which was one out of a total of 18 procedures. We noted that a further audit was planned to review the findings.

## Competent staff

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- Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. 17 of the 18 consultants working in obstetrics and gynaecology departments had revalidated and one was working towards revalidation in line with the timescale notified to them by the General Medical Council (GMC). Five of the 12 staff grade doctors have revalidated and seven were working towards revalidation in line with the timescales as notified to them by the GMC.
- The service had monitoring processes in place to ensure that doctors were working within the GMC revalidation guidelines and would be able to revalidate in line with the scheduled date agreed with the GMC. Medical staff working in obstetrics and gynaecology worked across both specialties and there were 18 consultants: 17 had been revalidated at the time of the inspection and one was working towards revalidation in line with the General Medical Council timescale.
- The majority of staff we spoke with had received their annual appraisal. As at 20 January 2016, 76% of midwives and 89% of medical staff in maternity had completed an appraisal. This was less than the trust's target of 90%. However 90% of nurses in gynaecology and 100% of medical staff in gynaecology had completed an appraisal.
- Not all staff received formal supervision. The service told us they recorded training and preceptorship as part of supervision for gynaecology nurses, supervision also occurred on an as required basis and was an on-going element of the appraisal process.
- The service told us 100% of midwifery staff received informal supervision in addition to the SoM.
- The Nursing and Midwifery Council (NMC) Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio in December 2015 was 1:21, which was above the recommendation of 1:15. The service told us that the HOM was aware of the current structure of Supervision of Midwifery at the Trust, and had agreed a local arrangement for enabling the Supervisors of Midwives extra time allocation for work related to Supervision, which is funded through the temporary staffing (bank) arrangements.
- The service employed a full time practice development midwife who was employed 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.
- A comprehensive induction programme for newly appointed staff was tailored to their roles. This included a range of training courses such as care of intravenous therapy.
- Newly appointed midwives attended a tailored induction course, PROMPT training. The course included: CTG training, K2 training, infant feeding, diabetes, antenatal screening, suturing and training on HIV.
- All staff in the maternity department were given a personal training booklet. It was to be retained and maintained by themselves and presented at their annual appraisal. It stated in the record that staff would not be able to progress to their next yearly pay point if all their mandatory training was not up to date.
- Competencies of existing nursing, midwifery and support staff were assessed throughout the year. There were also specific competency assessments for theatres and use of equipment such as CTG machines.
- Clinical staff told us they regularly held practices to maintain and improve the skills needed in the event of an emergency, for example neonatal resuscitation.
- The maternity service held stage two baby friendly accreditation. Stage two accreditation is achieved when a service demonstrates that all staff who are providing breastfeeding support and care for pregnant women, mothers and babies had been educated according to their role.
- There was an 18 month preceptorship programme for newly qualified midwives from which they would be promoted to band 6 on completion of relevant competencies. Each preceptor was given a booklet to record assessment of their competencies which was submitted to the practice development midwife.
- Newly qualified midwives and new to post midwifery care assistants worked in a supernumerary role for one month. This allowed them to gain sufficient role specific competences.
- Medical staff we spoke with told us there was support for them when they were completing MRCOG (Member of the Royal College of Obstetricians and Gynaecologists.) They had access to the MRCOG forum and one to one teaching via their supervisors.
- The service maintained a spreadsheet of all professionals as well as their registration number with professional bodies such as the general medical council and nursing and midwifery council. All professionals were required to update their registration annually.

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- Staff told us they were encouraged and given opportunities to develop. The Directorate had a hysteroscopy nurse in training to cope with the increased need for outpatient hysteroscopy, once training was completed and signed off as competent, the nurse would run their own clinic. This was planned to be in place by the autumn 2016.
- We saw that the termination of pregnancy service carried out three surgical terminations between April 2014 and March 2015. The service supported medical staff to maintain their competency by ensuring that those Consultants and Registrars undertaking surgical TOP maintained experience in suction evacuation of retained products of conception (ERPC) which is a similar process for women following miscarriage. The unit had a dedicated weekly ERPC list which had at least three or four cases of ERPC of various gestational ages ensuring competency was maintained. The staff involved in surgical TOP performed regular ERPCs.

## Multidisciplinary working

- The staff we spoke with reported good multi-disciplinary (MDT) working. Staff reported medical and nursing / midwifery staff worked well together.
- We saw effective communication between consultants and midwives. Communication with community maternity teams was efficient. In the community, we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services.
- 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 TOP service, and saw detailed discharge letters and a review of contraception in all five sets of records reviewed.
- A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients. We observed one medical handover where patient care was discussed and discharges planned.
- We listened to a handover on the gynaecology ward. A printed sheet containing women's details and care

needs was used for this process. We observed positive interaction between staff so that there was a good understanding of each woman's needs for the remainder of the day.

- We observed a night handover on the delivery suite, a printed sheet containing women's details and care needs was used for this process. Each woman on the unit was discussed by the shift leader and midwives were allocated to women for their shift. Detailed information was given which provided a good summary of each woman's needs.

## 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.
- 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. Information was also stored electronically.
- 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

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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.

- Mothers used hand held notes for the duration of their pregnancy; these were scanned and stored in their electronic notes following their discharge from the service.
- The community team were about to commence the use of an electronic tablet (planned to start in February 2016). Information collected on the tablet such as the antenatal booking form would be updated on the patient's records when the community midwife accessed a Wi-Fi hot spot, usually when they returned to the hospital.
- Postnatal appointments with community midwives, following transfer home, were routinely made by staff when women were ready for discharge. Women were given written details about this and the care they could expect to receive in the community. We observed a discharge and noted the written information including contact details were explained fully to the woman before they left the service.

## 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 12/02/2016 for Maternity and Gynaecology was 95% for nurses and midwives and 74% for medical staff. The service told us all staff will have completed mandatory training by the end April 2016.
- The hospital had set procedures in place for assessing patient's capacity, whether they came into the hospital as an emergency or a planned admission. Staff we spoke with talked confidently about mental capacity assessments within the remit of their role.
- 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 (WHO) checklist had been followed.
- The service had carried out an audit for consent prior to surgical procedure. In September and October 2015. A selection of 40 set of records were randomly selected and reviewed including caesarean section, instrumental deliveries and spontaneous vaginal delivery (SVD)

requiring perineal suturing in theatre. Audit findings revealed that the patient and professional had signed the consent form in 100% of cases and the procedure or intervention was described on the form in 100% of cases. The findings were discussed at the delivery suite forum and the results were emailed to all obstetric consultants, senior and junior doctors.

- 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 demonstrated a clear understanding of Gillick competencies. (These helped clinicians to identify children aged less than 16 years of age who have the legal capacity to consent to medical examination and treatment).
- We were told the completion of certificate for terminations in line with the Abortion Act (1967) and Abortion Regulations (1991) was carried out by two clinicians, which is in line with the legislation. We saw this was completed in the five sets of TOP notes we reviewed.

## Are maternity and gynaecology services caring?

Good



Overall, we rated services as good for caring because:

- The majority of women and their relatives we spoke with were positive about the care they had received.
- The Friends and Family Test (FFT) results showed that the service generally performed better than the England average for percentage of patients who would recommend the service for the postnatal ward and the birth services.
- In the 2015 maternity survey, the service performed the same as other trusts in the three main areas, labour and birth, staff during labour and care in hospital after birth.
- Staff were caring, kind and considerate.
- Women and their partners felt involved with their care and were happy with explanations that were given to them.
- Women's privacy and dignity were promoted.

## Compassionate care

# Maternity and gynaecology

- Women and their relatives we spoke with were very positive about the care they had received on the delivery suite, MLBU and antenatal wards. One mother told us that they were “very happy with their care, their needs had been met before they had chance to ask for help.”
- Most of the women we spoke with were happy about the care they had received on the post-natal ward and gynaecology ward. On the post-natal ward, some women commented about isolated incidents where they had to wait for their care needs to be met. They told us that that they had been very aware that the staff were very busy and were often dealing with complex situations.
- Mothers we spoke with said that they did not feel that they were being ignored; they felt that the postnatal ward felt short staffed at times and this had impacted on the staffs’ ability to respond quickly.
- We were told that, on occasions, patients on the gynaecology ward had been temporarily placed in a bed in the day room, due to bed pressures. We saw that one patient had used this area for three nights the previous week. We were told that whilst the staff had made every effort to make the area comfortable, such as arrange temporary curtains to ensure privacy, the environment was not ideal as there was no call bell, the area was next to the toilets and she was disturbed when other patients were using them and the lights were often left on. Despite this, patients told us that the “care on the ward was outstanding, I felt completely cared for”.
- Women we spoke with told us that they had been treated with kindness, dignity and respect. They felt that staff spoke to them at their level and had provided them with the necessary support. They commented about how friendly and cheerful staff were; one patient told us that there was such a friendly atmosphere on the gynaecological ward.
- We observed staff respecting women’s dignity by knocking and waiting to be invited into the room. Staff waited outside curtains and asked for permission to enter. We saw good interactions between staff and relatives.
- The Friends and Family Test (FFT) results for the time period between December 2014 and November 2015 showed that the service generally performed above the England average for percentage of patients who would recommend the service for the postnatal ward. The percentage of patients who would recommend the

service for the birth services was above the England average between July 2014 and November 2015. In November 2015, the service scored 98% for postnatal care and 97.8% for birth.

- The service had mixed performance for antenatal care and generally scored below the England average for postnatal community provision. The lowest score for antenatal care was 80.9% in March 2015 and for postnatal community provision, the lowest score was 79% in August 2015.
- In the 2015 maternity survey, the service performed the same as other trusts in the three main areas, labour and birth, staff during labour and care in hospital after birth.

## **Understanding and involvement of patients and those close to them**

- Women we spoke with during the antenatal period said they had been given choices about birth and where they wished to be for their birth.
- The women we spoke with in the maternity unit all reported that communication was good throughout their pregnancy and that their partners had been involved.
- Women on the gynaecology ward told us that all staff had communicated well with them and that they had understood about their care throughout their stay on the ward.
- Women we spoke with in the antenatal clinic told us that they were happy with the service they received. They told us that sometimes there were delays in being seen but staff always informed them of the delay and the possible time scale involved.
- The EPS facilitated a monthly evening miscarriage meeting supported by The Miscarriage Association. The EPS lead used feedback from this to adapt the care they provided. For example, it was fed back that some patients found particular terminology distressing to hear so the service communicated this with all staff and the staff adapted their approach.
- We saw that the consultant held a discussion with the women attending the termination service to determine the degree of certainty of their decision and their understanding of its implications. There were detailed notes of this discussion in the five sets of notes we reviewed in the TOP service.

## **Emotional support**

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- Birthing partners were encouraged to stay with their partners on the MLBU, which provided extra support to women and facilitated early bonding for the family unit.
- At the time of inspection, the service did not employ a full time bereavement midwife although there was one bank midwife who had specialist knowledge in bereavement who attended the service to support mothers. Four additional members of staff were trained in the provision of bereavement support. We understand the trust intends to recruit a bereavement midwife.
- Patients we spoke with on the gynaecological ward said they were happy with the surgical and nursing care they had received. They told us they had been involved in the decisions made and staff were helpful by taking time to explain their health needs.
- We saw that support for women who had suffered a miscarriage; they were invited to attend a miscarriage support group which was held monthly supported by the Miscarriage Association.
- Staff we spoke with both in maternity and gynaecology told us they referred patients on to services that provided counselling to assist women in coming to terms with their condition and circumstances when necessary. They used services such as SANDS (stillbirth and neonatal death charity), CHUMS (child bereavement and trauma service) and The Miscarriage Association.

## Are maternity and gynaecology services responsive?

Good



Overall, we rated the service as good for responsiveness because:

- People's needs were consistently met through the way services were organised and delivered.
- Women always had a named midwife responsible for their care.
- During the inspection, we saw examples of how staff responded to women who had complex needs and those who needed urgent assistance.
- The service consistently met the 92% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment for gynaecology.
- Women who had an elective caesarean section were given a date to enable them to make preparations for the birth.
- There were arrangements in place for women who did not speak English. Leaflets in other languages for example Polish and Urdu were freely accessible on all wards we visited.
- The TOP service offered the abortion procedure within five working days of the decision to proceed.
- Concerns and complaints procedures were established and generally effective. Information was available for patients regarding how to make a complaint.

However, we also found that:

- Whilst bereavement arrangements were in place, there was not a substantive bereavement midwife in post at the time of our inspection, a business case had been submitted for this role.
- Information leaflets provided by the termination of pregnancy service were only available in English which did not reflect the local population.

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

- The service, working with the clinical commissioning group had commenced a local maternity services liaison committee (MSLC) in October 2015. The MSLC provided a forum for parents and health professionals to work in partnership to plan, monitor and improve maternity services in the local area. We saw minutes of the first meeting, which set the terms of reference of the meeting. We saw meeting dates set for 2016.
- Women could access the maternity services via their GP or by contacting the community midwives directly.
- Community midwives offered an on call service to support women who were planning to have a home birth. Women were given an informed choice about where to give birth depending on clinical need.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The personal child health record (PCHR) was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- The hospital offered early pregnancy assessments, foetal assessment, antenatal clinics, a triage unit, scanning sessions and gynaecology clinics.

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- There was a dedicated antenatal clinic for women who had gestational or long-term diabetes to enable their health needs to be addressed in conjunction with their pregnancy.
- The trust had a self-referral system for women seeking treatment for termination of pregnancy.
- The Hospital redevelopment plan for 2017 aimed to provide a new delivery suite, midwifery led birthing unit and triage area for women. Plans for the redevelopment included a new unit with eight midwifery led birthing rooms, 12 obstetric led birthing rooms, three dedicated obstetric operating theatres and an eight bedded triage area. It was planned that the birthing rooms would have ensuite bathrooms and natural lighting. The midwifery led unit would have a birthing pool.
- The new unit would have a central, outdoor courtyard for women to use. The unit would be designed in line with health building note guidance (HBN 09-02: Maternity Care Facilities), There would be a dedicated bereavement suite, sensitively designed with a dedicated entrance and exit for families.
- Many of the specialist gynaecology clinics such as colposcopy, hysteroscopy and uro-dynamics were carried out in a purpose built area on one of the ward areas. The trust redevelopment planned for 2017 would provide a dedicated suite of operating theatres with a co-located surgical arrivals lounge to support patient flows for day surgery.

## Access and flow

- Women who were at low risk could access the midwife-led birthing unit (MLBU). The MLBU provided single room facilities. Low risk was characterised as term pregnancy between 37 to 42 weeks, a singleton pregnancy (one baby, not multiple pregnancy), cephalic presentation (head first) nonmedical or obstetric complication and pre labour haemoglobin over 9.0g/dl.
- Community midwives carried out home assessments and home deliveries. There were 95 home births between January and December 2015.
- There were two closures of the Maternity Unit between July 2014 and June 2015. The longest time the unit was closed for was 16 hours in October 2014. Both closures were due to capacity issues. We saw that since these episodes of closure, a number of improvements had been implemented. For example a manager of the day, who was on call 24 hours a day seven days a week had been introduced. This had enabled issues to be immediately addressed and capacity and flow had been maintained. An escalation policy had been developed with RAG rating to ensure that staffing capacity and acuity could be managed in a timely manner. Formal structured obstetric ward rounds had been established which supported post-natal pathways. Midwifery led discharges and an enhanced recovery guideline had been developed. The department had a rolling recruitment process, and a workforce group had been established to review projected workforce over the next five years and develop appropriate roles to support an appropriate skill mix across the maternity service.
- Bed occupancy ranged between 57% and 64% between October 2013 and September 2015, which was in line with the England average of between 57% and 62%.
- The gynaecology ward had created contingency beds within the day room on the gynaecology ward. This was part of the contingency plan for managing bed shortage. The service told us this was a result of a rise in both elective and emergency activity over the past year. Emergency gynaecology patients that presented to the emergency department and were referred immediately to the gynaecology on call team. These patients were transferred to Ward 34 for assessment and decision to admit. It was felt preferable to extend the capacity of Ward 34 by two (temporary) beds rather than admit patients to the general assessment units.
- The gynaecology department did not have a dedicated assessment/admission unit. The service acknowledged that this had a negative effect on the patient experience; both for those in the beds and for those who had otherwise have used that area to wait for a bed. It had also created the need for extra staffing at night, often the hospital had used agency to cover this need as current establishment did not cover this need. Plans had been agreed to convert the area used for these two beds into a dedicated admissions and discharge facility. It was envisaged that work would be undertaken during year 2016. Beds were placed in the day area open on nine occasions over the past 12 months. Nurse staffing reflected the additional capacity with an increase in a registered nurse on night duty.
- The outpatient service had a common waiting area that was shared between maternity and gynaecology services.
- The labour ward rooms were appropriate for their intended use and provided a safe environment.

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- The bays on the gynaecology ward resulted in beds positioned very close together. This restricted privacy and ability to hold confidential discussions. Patients were offered to go to a more private area on the ward to have private discussions.
- 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.)
- Between December 2014 and November 2015, the service consistently met the 92% standard for percentage of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment for gynaecology. For the 12 month period 97.5% of patients under the specialty of gynaecology had an incomplete pathway (patients waiting to start treatment) of less than 18 weeks.
- The service carried out 92 medical terminations between April 2014 and March 2015 in the termination of pregnancy Service (TOP). The TOP clinic was provided from the ambulatory gynaecology clinic, 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 to ensure that women were offered the abortion procedure within five working days of the decision to proceed.
- Women attending appointments in the TOP service received details of a 24-hour telephone helpline number to use if they had any concerns. Referrals were made to the EPU by GPs, patients could also self-refer.
- The unit had two operating theatres and a third auxiliary room (suitably equipped, for example had an anaesthetic machine and operating table) could be used for emergency delivery if theatres were occupied. These theatres were used for non-elective Obstetric deliveries as well as elective caesarean deliveries. Elective minor surgeries were performed in one of the theatres on a Tuesday and Friday afternoons only. The service told us that aim was to move these to the main hospital theatres by the end of 2016. They had submitted a business case to the board to request this move.
- We were told that in instances where an elective CS list was interrupted by an emergency and led to a list overrunning or cancellation the woman was brought in within 24 hours (next day). We saw that in the period December 2014 to November 2015 a total of 69

gynaecology operations were cancelled. 39 were due to theatre capacity. The trust told us that the reasons for the cancellations for theatre capacity were mainly due to theatre overruns of complex cases.

## Meeting people's individual needs

- We observed the care and treatment provided for a woman in the labour ward who had complex needs. Staff responded promptly by developing a comprehensive care plan that met the woman's sensitive personal needs and health needs. We saw that staff adhered to the care plan
- There were arrangements in place to support women who had complex needs, such as diabetes and mental health needs with access to clinical specialists and medical expertise. The service employed a diabetes clinical specialist midwife and a mental health clinical specialist midwife. There was a designated safeguarding midwife.
- 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.
- We saw evidence of women being offered 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 risks identified had made home birth not advisable so a change to the consultant led unit was chosen.
- The staff we spoke with told us that if a patient who used the service had any specific needs, whether these were mental health, learning disability, social needs or safeguarding, they would contact the midwife safeguarding lead or the service safeguarding lead as well as referring to guidance on the intranet for advice. We saw evidence of this in practice during our visit. Staff recognised that patients who had a learning disability needed extra time and care. Family involvement was encouraged.
- We saw there were processes for screening for foetal abnormality. Women identified with a high risk of foetal abnormality, such as Down's syndrome, (Down's syndrome, is a genetic condition that typically causes some level of learning disability and characteristic physical features) were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.

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- Women received care from the same midwife in the community for their pregnancy and following birth, which provided consistency.
- Partners could visit between 10am and 10pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies.
- We were told women who used the service who were unable to speak English fluently could access an interpreter service if required. An interpreter could be booked to attend appointments or inpatient services if necessary; a telephone service was also available. We saw information about the translatable services available advertised through the service.
- Staff we spoke with were aware of the need to access independent translatable services for women to reduce the risks such as putting family members in uncomfortable positions in which not all information would be accurate or family purposely withholding information.
- The majority of information leaflets we saw were provided in different languages, we saw leaflets in English, Urdu and Polish. However, we saw that the leaflet provided information about medically induced abortion was only provided in English.
- The Information videos on the service's website, for example the delivery room tour and the midwife-led birth unit tour were available in English, Polish and Urdu.
- There were videos on the hospital website, which allowed the mother and those close to them to have a virtual tour of the service. They provided information about what to expect during their first, second, third trimester and when they were in labour. The videos gave post-natal advice and what to expect following the birth of their child. There was also information provided such as what to do when they went into labour or if their waters had broken and how to access the hospital out of normal day working hours. The website also provided information such as concessionary parking available via midwifery, refreshments facilities security and infection control information. This information was also available in leaflet form.
- A standard delivery room had been converted with the support of a local charity into a bereavement room to ensure bereaved parents had personal time with their baby, the room had been appropriately decorated and was located so that bereaved families could have minimal contact with other new mothers if they preferred to ensure bereaved parents had personal time with their baby.
- Bereavement arrangements were in place, whilst there was not a substantive post bereavement midwife in post at the time of our inspection a business case had been submitted for this role. The service had a bank midwife whose role was predominantly to support and educate midwives. We saw a bank midwife who had specialist knowledge in bereavement attended the service to support mothers when necessary. The service has submitted a business case for a substantive post. At the time of the inspection, this post had not been agreed.
- Mementos such as photographs and information about making a memory box were given to parents. Parents were supported in making funeral arrangements and where necessary counselling services were organised. The hospital chaplain offered support to parents who faced the loss of their child. The chaplains and chaplaincy team at the hospital offered confidential support to all patients, visitors and staff of any faith or no faith.
- The hospital had a full time lead chaplain who co-ordinated the work of the chaplaincy with chaplains and volunteers drawn from many faith and cultural communities. Chaplains of various denominations and faiths regularly visited the hospital, or attended when requested.
- All of the women we spoke with told us they were offered a choice of meals, which were provided at the bedside if they were unable to obtain their own meal. However, most of the women told us whilst the meals were sufficient they were quite bland with limited choice. One patient commented that the meals were like "a good school dinner".
- The service was working with a UK-based weight loss organisation. Together they were working with expecting and new mums to support them with weight management and healthy eating. They had introduced a new group aimed at woman planning to have a baby as well as expectant and new mothers. Women with a body mass index (BMI) greater than 30 were offered additional support through sliming world free of charge.
- The outpatients appointments for gynaecology coincided with antenatal appointments and women attending for these appointments shared the same

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waiting room and clinic times this meant that patients who may be having difficulty in conceiving were sharing the same area with pregnant women and this was not sensitive to their needs.

- There were no disabled toilet facilities in the outpatients department, people requiring this facility had to access the main hospital facilities.
- Staff provided women who had undergone termination of pregnancy 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 all five sets of TOP notes we viewed.

## Learning from complaints and concerns

- We saw information leaflets for patients and those close to them informing them of how to raise concerns or make complaints.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint
- Information from the service indicated that there had been a total of 60 complaints received for Women's Services during the period of January 2015 and January 2016. 22 for obstetrics, 14 for midwifery, 24 for Gynaecology. 48 complaints have been closed with 12 formal complaints open pending responses for Women's Services for the period of January 2015 and January 2016. Information about complaints were shared with the relevant team, for example we saw evidence of learning in team meeting minutes.
- The Early Pregnancy Service (EPS) had received no complaints in the past 18 months. The department sent out patient surveys each November to gauge patients' response to the service. The response for November 2015 was 100% positive about the service they had received
- People we spoke with who used the service were aware of how to make a complaint or raise concerns.
- Learning from complaints was integrated with the governance arrangements. They included formal review to ensure appropriate actions had been taken.

## Are maternity and gynaecology services well-led?

Good



Overall we rated the service as good for being well-led because:

- There was a clear governance structure in place and meeting minutes were well documented;
- Senior leaders understood their roles and responsibilities in overseeing the standards of service provision;
- The service had a focused direction defined by strategic aims and a vision for the services;
- There were processes in place for gauging patient and public perception of the service and action plans were developed to improve the service based on the results;
- The culture of the service encouraged candour, openness and honesty;
- There were some good examples of services which provided excellent care beyond that of a typical district general hospital. For example, the endometriosis service.

However, we also found that:

- The service risk register lacked information about the assessment of the likelihood of the risk materialising, its possible impact or a detailed action plan. Many of the items did not have a current review status.

## Vision and strategy for this service

- The trust had launched the nursing and midwifery strategy 'Proud to care at the L and D' in October 2014. It aimed to guide and steer the service's practices, making clear ambitions for nursing and midwifery. The service told us that it has been developed through a process of engagement with nurses and midwives and other care staff from across the organisation and there had been engagement with patients. The maternity and gynaecology staff we spoke with were aware of this strategy.
- The leadership team told us they had a vision for the service which had been translated into a five year strategic plan. The plan aimed to expand the Women and Children's centre. Within the maternity unit, the aim was to provide seven day consultant cover and

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presence, in line with Royal College Guidelines supported by a level 3 neonatal intensive care unit and inpatient paediatric services. The service aimed to work collaboratively across diabetes and maternity services to develop a diabetic pregnancy service as well as re-designed pathways for antenatal and postnatal care and community gynaecology. They aimed to complete further pathway redesign for antenatal and postnatal mothers.

- The strategic plan was written following recommendations from the Francis Report (2013) and the Government's response 'Putting Patients First' (2013). The strategy provided a plan to drive the development of new roles, new ways of working and new ways of delivering education and training working towards ensuring they had a "workforce that was fit for purpose".
- Staff we spoke with were aware of the service's vision, although not in detail, they were able to discuss the main focus. There were posters displaying the service's vision around the unit and wards.
- The maternity department had an action plan, which had incorporated the findings of the two external reviews of the service. The first was in November 2014 and the second in March 2015 and included the review using birth-rate plus and the finding of the Kirkup report. The overarching aim of the report was to improve the experience of women and their families underpinned by world class values.
- There were 10 key areas identified, for example; antenatal screening, education and development, staff experience, leadership and staffing structure. The plan detailed how these would be achieved and within what timescale.
- The action plan was reviewed and progress was fed back to the executive team, at the obstetrics and gynaecology governance and risk committee meeting (GRCM) and at divisional meetings. The majority of staff we spoke with were aware of main focus of the action plan.
- There was an executive director and a non-executive director with responsibility for maternity services who provided representation of maternity and gynaecology at board level.
- The leadership team told us they had a vision for the service which had been translated into a five year strategic plan. The plan aimed to expand the Women and Children's centre. Within the maternity unit, the aim

was to provide seven day consultant cover and presence, in line with Royal College Guidelines supported by a level 3 neonatal intensive care unit and inpatient paediatric services. The service aimed to work collaboratively across diabetes and maternity services to develop a diabetic pregnancy service as well as re-designed pathways for antenatal and postnatal care and community gynaecology. They aimed to complete further pathway redesign for antenatal and postnatal mothers.

## Governance, risk management and quality measurement

- There were monthly governance and risk committee meetings (GRCM), which reported to the service clinical governance group who reported directly to the hospital board. The GRCMs were responsible for reviewing incidents and monitoring trends and to ensure lessons were learned and shared. The minutes we reviewed were detailed, contained copies of the relevant reports such as a dashboard and the relevant current evidence based practice.
- Review of the October 2015 GRCM minutes confirmed that incidents were discussed in detail. Incidents that required further investigation had a named person responsible as well as a proposed date for completion.
- The service had a risk register, which identified each risk in detail alongside a description of the mitigation and controls in place. Managers we spoke with were aware of the top risks on the divisional register.
- However, the register lacked information about the assessment of the likelihood of the risk materialising, its possible impact or a detailed action plan. Many of the items did have information on the most recent review date but only some of the risks had information about when the risk was due for review. There were risks identified from 2008 without a current review status. We raised this at the time of the inspection and we saw that the senior team took steps to review their risk register.
- There was a clearly defined audit plan within the Obstetrics and Gynaecology services for 2015/16. The service told us there was a programme in place for women's services to ensure they were continuously improving their patient care, which was informed by national guidance, patterns of incidents and clinical data outcomes. Findings from these audits were fed back to the relevant team. Staff told us that they received feedback in various ways.

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- Performance issues were taken up with the individual staff member.
- The maternity and gynaecology departments each maintained a quality and performance dashboard, which reported on activity and clinical outcomes. The dashboard data was compared with safety-related targets on a monthly basis and fed back to the relevant teams.
- The service had a risk management policy, which identified local arrangements for the Maternity Service's integrated governance approach. This was in line with the trust's Risk Management Strategy and Policy, in terms of the management arrangements and processes for the identification, assessment, treatment and monitoring of clinical risks.
- Staff we spoke with said they felt confident that if they needed to report serious concerns following the service's whistleblowing policy that they would be listened to. Medical staff we spoke with said there was a no blame culture within the hospital. We saw evidence of a culture that encouraged candour, openness and honesty.
- Staff told us that there was a good working relationship between medical staff and midwives.
- Medical staff told us that they had support from senior colleagues. They told us the hospital was a good placement and they were provided with wealth of education. One told us that their children had been born at the hospital, as they were happy with the care provided.

## Leadership of service

- There was a clear management and accountability structure in place for medical staff, midwives and nurses, which included community midwifery.
- The head of midwifery (HOM) was relatively new in post and had made some changes to how the service was managed including additions to the staffing structure. The majority of staff we spoke with told us the changes were well received and had improved staff morale.
- The HOM reported to director of nursing which gave her access to the trust board.
- There were consultant leads for specific services within obstetrics and gynaecology for example; there were leads for colposcopy, TOP.
- There were also specialist roles within midwifery, including, a consultant midwife, safeguarding midwife and a training and development midwife.
- Staff told us the management team were very visible and they could approach them to discuss any issues. Staff were given opportunities for professional development.

## Culture within the service

- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they delivered.
- Midwifery staff were flexible and told us they worked hard to support each other. They all had a strong commitment to their jobs
- The majority of staff we spoke with told us they felt their managers were supportive and approachable. Staff we spoke with felt respected and valued.

## Public engagement

- Data from the Friends and Family Test was used to monitor and influence the standards of the services provided.
- The Early Pregnancy Service lead nurse used feedback from monthly evening miscarriage meeting to adapt the care they provided. For example, it was fed back that some patients found particular terminology distressing to hear so the service communicated this with all staff and the staff adapted their approach.
- The service carried out a one to one care in labour audit in October 2015. This audit aimed to assess women's' perceptions of midwifery care provided to them throughout the intrapartum period. The audit reviewed elements of care such as one to one care, whether the women were able to move around in labour and choose positions most comfortable to them and whether they had been left alone. This information was fed back to team.
- We saw the colposcopy clinic carried out annual patient satisfaction surveys and as a result from the last survey (November 2015), the team extended the clinic time in the late afternoon.
- The service participated in the MSLC. The current group was commenced in October 2015. The MSLC provided a forum for parents, health professionals and the local clinical commissioning group to work in partnership to plan monitor and improve maternity services in the local area. We saw minutes of the first meeting, which set the terms of reference of the meeting. We saw meeting dates set for 2016.

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## Staff engagement

- There was an annual staff survey, which sought the views of staff perception about working for the organisation.
- Staff had the opportunity to provide feedback daily at handover meetings, monthly team meetings as well as during their supervision or appraisal.
- The senior management team told us how they had engaged with the team to make the changes in maternity identified by the external review.
- The changes required such as reconfiguration of the staffing on the wards were shared with the team and staff encouraged to be involved in the process. There was mixed opinion from staff about their involvement in the service changes.
- Information was cascaded via meetings, the quarterly newsletter and by individual emails.

## Innovation, improvement and sustainability

- During the inspection, the executive team gave a presentation about the improvements that were being planned for the redevelopment of the women's and children's service in 2017. This would address the environmental issues caused by the current building.
- We were told about the department's involvement with the Flying Start initiative, which was started in January 2014. This innovation involved partnership working with children's centres, primary care and Luton local authority to improve health and social outcomes from pregnancy to the age of five. The flying start workers worked alongside the midwives providing support to families that needed support.

- The service had introduced practice facilitators to support newly qualified midwives and midwives who were new to the service.
- The service was working with a UK-based weight loss organisation. Together they were working with expecting and new mothers to support them with weight management and healthy eating. They had introduced a new group aimed at women planning to have a baby as well as expectant and new mothers. Women with a body mass index greater than 30 were offered additional support through sliming world free of charge.
- There was evidence of information technology supporting clinical practice. A Maternity App had been developed in partnership with an IT developer and was in the early stages of implementation.
- The service had significantly invested in providing community midwives with remote access to IT services, which enabled staff to update and read patient records.
- The gynaecology department had invested in the development of the ambulatory gynaecology outpatient department. It provided outpatient hysteroscopy (hysteroscopy is a procedure used to examine the inside of the uterus (womb, outpatient management of miscarriages using MVA (manual vacuum aspiration) and outpatient cystoscopy.
- The hospital had an Endometriosis Regional Centre, which was accredited for advanced endometriosis surgery within the region.

# Services for children and young people

Safe	Good	
Effective	Outstanding	
Caring	Good	
Responsive	Good	
Well-led	Outstanding	
<b>Overall</b>	<b>Outstanding</b>	

## Information about the service

The children and young people's service at the Luton and Dunstable University Hospital NHS Foundation Trust provides a service for neonates, children and young people up to and including age 16 years. Children 16 to 18 years were cared for on adult wards with input from paediatrics as necessary. The service included 54 inpatient beds across three wards; Squirrel (Ward 24), Rabbit (Ward 25) and Hedgehog (Ward 26) and included four high dependency beds and a five bedded paediatric assessment unit (PAU).

The Neonatal Unit (NNU) had been the lead unit for Bedfordshire and Hertfordshire since 2003 and had 11 Level 3 intensive care cots (NICU), eight Level 2 high dependency cots (HDU) and 18 Level 1 on the special care baby unit (SCBU). At the time of the inspection the number of NICU cots had been reduced to nine due to nurse staffing shortages.

There was also a children's emergency department (ED) which was inspected by the urgent and emergency care team.

The PAU provided a seven day, 24 hours rapid paediatric multi-disciplinary emergency assessment for acutely ill children and young people. It also provided open access for children and young people living with on-going illnesses and supported other departments with difficult blood sampling and cannulation.

Between January 2014 and December 2014 8,932 children had attended the trust, of which 74% were emergency admissions.

However for the period April 2014 to March 2015, there was a total of 85,676 contacts including outpatients, ward attendances, ED and admissions to any wards.

This was due to some children attending more than once. An additional 7,481 children attended the emergency department and were directed to an urgent GP appointment.

Between January 2015 and December 2015, there were 9,089 inpatient admissions of which 528 were elective, 793 were day cases and 7,768 were emergency admissions. Of these 264 were within the NNU or healthy baby admissions.

Between April 2015 and December 2015 the PAU had 5,952 admissions of which 1,030 were open access, 1,090 from their own GP, 2,546 from children's emergency department with the remainder from out of hour's services and urgent care centres.

Between April 2015 and December 2015, there were 1,119 elective admissions for children and young people's surgery. The majority was related to ENT surgery (551), followed by oral maxilla facial (233), general paediatric surgery (153) and trauma and orthopaedic surgery (130).

During the inspection, and in order to make our judgements, we visited inpatient and outpatient areas. We talked with 11 patients and/or their parents, and 47 staff including nurses, doctors, physiotherapists, a play specialist, support staff and managers. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed 14 care records, medication records and performance information supplied by the trust.

# Services for children and young people

## Summary of findings

Overall, we rated the service as outstanding.

We found there was a real passion and commitment to work as a multidisciplinary team delivering a patient centred and high quality service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.

Treatment and care by all staff was delivered in accordance with best practice and recognised national guidelines.

The service took part in national research programs and used the outcome of these to develop innovative and pioneering approaches to high quality care and monitored the safe use of these new approaches. The Neonatal unit (NNU) was the lead unit for Hertfordshire and Bedfordshire since 2003 and its high performance was recognised by external bodies. The NNU was one of 12 sites across the UK to participate in the SAFE project which was run by the RCPCH. This involved a core team from the service attending the programme and returning to implement and trial different models of care.

Both medical and nursing staff we spoke with were passionate about providing a holistic and multidisciplinary approach to assessing, planning and treating patients. This was demonstrated by regular multidisciplinary meetings and excellent communication with their patients and relatives.

There was a good track record on safety with lessons learned and improvements made when things went wrong. Staff knew how to report incidents.

Both the paediatric wards and the NNU were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented.

Staff felt valued and supported by their managers and received the appropriate training and supervision to enable them to meet patients' individual needs. Senior management had created an environment where staff knew how to raise concerns and following the duty of candour processes.

Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by a range of national audits such as the Royal College of Paediatric Child Health (RCPCH) National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA).

The NNU had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. Staff were very proud about their cooling service which they had developed and continued to deliver.

There was a range of examples of working collaboratively and the service used innovative and efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge, transfer or transition to other services.

Nursing and support staff provided flexibility within the department to provide high quality care that met patients' care needs. Staff were supported to develop and learn new practices. Junior medical staff told us they had returned to the service for a second time in their training as they felt it was a good place to learn and progress. The service had developed and provided courses such as children's assessment knowledge and examination skills (CAKE) courses and sugar, temperature, airway, blood pressure, lab work emotional support (STABLE) courses for staff which was accessed by external organisations. These had been accredited by the Royal College of Nursing, RCPCH and the local university.

There was a clear open, transparent culture which had been established within the leadership team. The service could demonstrate a clear vision and strategy for paediatrics which was led by a strong management team. Staff told us they felt consulted and part of the development of the strategy, they were engaged and enthusiastic about the new developments within the service.

# Services for children and young people

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to developing new approaches to care and treatment.

## Are services for children and young people safe?

Good



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

- Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon. We were given examples where learning had taken place and had changed practice. All incidents were analysed and reported to the monthly departmental meetings for further discussion and action.
- There was pro-active microbiological surveillance provided by the microbiology department where all consultants and senior nurses were sent a list of positive swab and blood cultures which allowed an overview for infection control across the NNU and children and young people's areas.
- There were quarterly safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs.
- Staff used 'closing the loop' ward rounds. Once the ward round was completed each case was reviewed to check what had been agreed and a plan of action was put in place. Staff told us it empowered them to participate and speak up on ward rounds.
- Wards were adequately staffed from both a medical and nursing point of view. Where shortfalls had been identified, the senior team were aware and action plans were in place to address this. For instance there were 15 whole time equivalent (wte) nurse posts vacant. The service had advertised and recruited nine staff and was continuing recruitment abroad. This led to the closure of two cots on the NICU until all posts had been filled.
- The NNU complied with British Association of Perinatal Medicine (BAPM) 2010 standards. There was an average of 20.9 hours a day consultant presence Monday to Friday and a consultant presence at weekends.

However, we also found that:

- There was inconsistency in recording on drug charts. The ward pharmacist was an independent pharmacist prescriber and was able to amend or add prescriptions

# Services for children and young people

to correct errors. The pharmacist had introduced regular meetings with nursing and medical staff to make them aware of these interventions and reduce the risk of errors recurring.

## Incidents

- There were two serious incidents reported between November 2014 and December 2015. These incidents were investigated thoroughly using root cause analysis and had been completed at the time of the inspection. Actions had been identified and implemented in order to prevent further risk to patient safety.
- There had been no never events reported. Never events are serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- From October 2014 to September 2015 there were 502 child related incidents reported to the Women and Children's directorate. 239 were related to the NNU, of which 139 were attributed to NICU, 36 to HDU 15 to SCBU and two to the children's outpatient department (OPD).
- 263 incidents were reported from the paediatric service: 93 were attributed to Squirrel Ward, 25 to Rabbit Ward, seven to Hedgehog Ward, 27 to the PAU and four in the children's OPD.
- Of the 502 incidents, 12 were graded as causing no harm, 392 were graded as minor, 85 graded as moderate, 11 graded as major and two were graded as catastrophic. The two catastrophic events took place in the ED and were investigated and acted upon by the urgent and emergency care service.
- Staff told us parents were offered the opportunity to contribute to any serious incident which involved their child and received a copy of the investigation report with an opportunity to meet for discussion and updates. We saw evidence that this had happened.
- We were told by staff of learning from an incident which meant that all children who presented to the PAU with complex conditions would have a senior clinical review prior to discharge. We were also told of a change to the safe use of defibrillators; with checks in place to support appropriate energy levels for paediatric use.
- We saw an incident relating to the temperature in the milk fridge being too high which resulted in six mothers' expressed milk having to be thrown away. We saw the

- nurse in charge immediately inform all staff about the new location where expressed milk would be stored, complete an incident form and start to inform those whose milk had to be discarded. This demonstrated timely incident reporting and being open with the family as soon as the incident had been discovered. We saw evidence that further action was taken to expedite the work needed to get the fridge back into working order.
- The service provided us with examples of learning and changes being made from incidents where a daily checklist had been developed after a baby had been fed milk which was out of date. Expiry dates of milk were now checked as part of the daily safety checks by the nurse in charge.
- A further example demonstrated additional risk factors being added to the sepsis care bundle following one risk factor being missed when undertaking a neonatal septic screen.
- We observed twice daily safety briefings for staff and safety huddles where incidents were discussed and learning shared.
- Learning from all incidents was included in the mortality and morbidity meetings along with cascading of information from the risk leads by email, circulation of monthly pharmacy interventions /drug incidents and discussion at grand rounds. Grand rounds where when the trusts education centres presented medical problems to all members of staff on topics of general clinical interest and took action to improve where necessary.
- The January 2016 trust wide patient safety newsletter included learning from serious incidents. There was a range of examples used across the trust and included what went wrong and what actions were taken to prevent it happening again. This included incidents related to children and young people.

## Duty of Candour

- 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.

# Services for children and young people

- New staff received induction to the Duty of Candour as part of their induction and could tell us what this was. Nursing and midwifery staff received training as part of their annual mandatory training. Duty of candour regulations had been followed in terms of recent incidents.
- There were 'Being OPEN' Advisors who undertook E learning and were now awaiting further face-to-face training in order to support and train other members of staff to understand the Duty of Candour and its complexities.

## Safety thermometer

- The trust used the NHS patient safety thermometer. Between April and October 2015 there were no pressure ulcers, catheter related urinary tract infections or falls.
- The service had Quality and Safety Information Boards which were displayed in the staff room on the NNU and the nurse's office on the paediatric wards.
- On the paediatric wards, information from December 2015 included infection control results at 95% for cleanliness, handwashing 100% for both nurses and doctors, patient safety incidents and medicines errors, paediatric PEWS score recording 100%, overall Friend and Family Test score of 94% and staffing figures such as staff training 100%, sickness 3.01% and vacancies 7.48 wte. The board also included reminders of actions needed to be taken such as continued handwashing and E learning for conflict resolution.
- For the NNU information from December 2015 included vacancies (15 trained staff and two untrained), training 80%, sickness 4%, and appraisals 80%. The cleanliness audit showed waste bins were found to be overfilled, hand washing was compliant for nursing staff and needing further work for medical staff and there were three medicines errors. There were no complaints, 40 compliments and the Friends and Family Test was green. Actions related to implementing a risk factors care bundle and what the next training session for staff would be were displayed.

## Cleanliness, infection control and hygiene

- There were no methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile (C.Difficile) cases for the last year in the children's and young people's core service and no surgical site infections.
- The service used an electronic system which alerted staff to positive swab and bold cultures and was used

across the NNU and paediatric wards. This enabled staff to detect and act quicker when positive results were received. There was also a point of care testing for detecting respiratory syncytial virus (RSV) which was followed up by the laboratory. RSV is the virus that can cause severe and life threatening disease especially in neonates and young children. Medical staff considered this to be early microbiological thinking.

- The service had a monthly infection control audit which included hand hygiene, the environment such as patient bays, clean and dirty utility areas and equipment.
- For November 2015, the paediatric wards scored 100% for hand hygiene and were overall rated as amber with some areas needing attention. There was an action plan in place to make these improvements such as the estates team to repair some damaged cupboards, equipment to be cleaned /checked daily and documented and a review of storage space to reduce clutter.
- In October 2014, the NNU had an annual pseudomonas aeruginosa risk assessment review which resulted in a number of actions such as a review of documented flushing regimes, repair to a damaged wash basin and point of use filters to be fitted to taps. These had been completed at the time of the inspection. Pseudomonas aeruginosa is a bacterium which could affect the lungs, bloodstream, or heart valves in neonates.
- Infection control performance was displayed on the corridor at the entrance to the NNU and included an overall compliance of 93%, the environment 93%, equipment 98% and personal protective equipment 98%.
- The NNU had an 'Infection Control Plan' to support the trusts 'No Avoidable Infection Strategy'. This was aimed at eliminating Hospital Acquired Infections (HAI) and identifying specific action points for the NNU to reduce HAI in its patient population.
- This was a comprehensive plan that included areas such as improving hand hygiene, reducing the environmental load, improving levels of cleanliness, implementing antibiotic stewardship and improving the ability to contain infection. This also included who would deliver the plans, what resources were required, who would measure monitor and audit and what timescales were needed to deliver the plans.

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- We observed medical staff carrying out invasive procedures in NICU which followed good aseptic technique.
- We saw equipment was dated once cleaned and there was access to personal protective equipment, including gloves and aprons in all areas visited and staff used these appropriately whilst going about their activities.
- We observed staff on wards and the NNU complying with trust infection control policies, such as management of sharps, hand hygiene, the management of bed linen and the management of clinical waste. There was good access to hand washing and drying facilities, as well as hand sanitising gel.
- We saw cleaning schedules and checks on showers for legionaries' disease in place.
- The results of the Family and Friends Test in September 2015 to November 2015 showed five comments focusing on the environment being dirty. This, and other issues, were addressed through the trust outsourcing its domestic and catering contracts. Housekeepers were now in place seven days a week so more time could be spent ensuring the environment was clean.
- As at 30 November 2015, 82.5% of children's nursing staff had up to date training in infection control. This was above the trust target of 80%. In January 2016 figures for medical staff showed compliance was 76%. We were told by staff that this was due to staff sickness.
- The trust told us staff had been asked to complete their e-learning package by the middle February 2016. This had been raised with staff's training supervisor as appropriate to ensure the E learning was completed.
- In the 2014 CQC Children and Young People's Survey, the trust scored 90% for whether the hospital room or ward the child was seen in was considered to be clean. This was consistent with the England average.

## Environment and equipment

- In the 2014 CQC Children and Young People's Survey, parents and carers of children under 16 years of age were asked to say whether the ward where their child stayed had appropriate equipment or adaptations for their child. The trust scored 87% which was consistent with other trusts.
- The fabric of the building was dated and in need of a refresh. There was a plan for site redevelopment and provision had been included for the refurbishment of the current facilities across the paediatric service. This was planned to be completed by 2019. However changes were already taking place in order to improve areas such as facilities for parents.
- There was an Infection Control Action Plan for Squirrel, Rabbit and Hedgehog wards dated November 2015 which noted the schoolroom required oxygen, air and suction to support the winter pressure escalation along with Hedgehog Ward also needing oxygen, air and suction for every bed space.
- A risk assessment was carried out prior to the commencement of this programme of work and additional portable oxygen and suction was on the ward during that time. Work was also carried out when possible while the ward was unoccupied. The impact on the school room provision was mitigated by supporting bedside teaching and dedicated time using the playroom. This work had been completed at the time of our inspection.
- The Women and Children's risk register noted a lack of space between cots; this had been improved at the time of the inspection by taking our two cots to make more space.
- The risk register noted there was no rolling programme of replacement of equipment. This was a trust wide problem. However, staff told us this had not impacted on care and the service submitted capital bids as part of the annual capital programme. This had allowed a programme of ongoing investment.
- We checked the resuscitation equipment on all wards and areas and found the equipment was checked daily, cleaned and documented.
- Staff huddles included what checks were carried out each day such as the checking of controlled drugs, resuscitation trolleys, ventilators and monitors, hoists, scales, baby thermometers, intravenous cupboards, fridges and sluices. We observed the nurse in charge carrying out the daily safety checks across the NNU.
- Clinical waste storage was appropriate.
- The environment was safe for children as there was an intercom system in place and CCTV at the entrance to the unit.
- A fire risk assessment had been undertaken in September 2015 which resulted in two areas needing action to be taken. These were to ensure there were fire marshals on the ward and fire drills to be carried out. Both these actions had been completed.

# Services for children and young people

## Medicines

- From October 2014 to September 2015, there had been 135 drug incidents reported across the NNU, paediatric wards, PAU and children's outpatients. For the NNU 46 were graded as minor and four as moderate. The four moderate incidents related to missed doses of medication and administration errors.
- 84 incidents were reported in total with Squirrel Ward (36), Rabbit Ward (30), Hedgehog Ward (7) and children's OPD (2), with the remaining nine incidents reported from various locations across the trust. 74 incidents were graded as minor, nine graded as moderate and five graded as causing no harm. Of the nine moderate incidents five were due to either a dispensing or administration error.
- We saw medical and nursing staff carried paediatric quick reference cards which included the age-related normal values for observations which would support the early identification of patient risk and APLS algorithms. There were also resuscitation drug dosages for safer prescribing in an emergency.
- The ward pharmacist was an independent pharmacist prescriber and was able to amend or add prescriptions to correct errors. We saw that the pharmacist had introduced regular meetings with nursing and medical staff to make them aware of these interventions and reduce the risk of errors recurring. The ward manager told us medicine errors were shared with staff at daily meetings and we saw that the ward newsletter included learning from recent incidents.
- The pharmacy team carried out quarterly safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs. The results of the audit undertaken in September 2015 showed for paediatrics 25 out of a possible 33 standards the areas scored 100% and the NNU scored 29 out of a possible 32 standards. Action plans were in place to improve the areas that did not score 100%.
- Fridge temperatures were checked and documented on all wards and children's areas. We checked controlled drugs were stored correctly and the register was completed.
- The service used a comprehensive prescription and medication administration record card which facilitated the safe administration of medicines.
- A senior pharmacist visited the ward most days and stock was replenished by pharmacy technicians. Nursing staff told us they received a good service from the pharmacy team.
- The ward manager told us safety alerts relating to medicines were distributed to the ward, and gave us an example from November 2015 about the use of an antibiotic in children under one year.
- We observed nurses administering medicines in accordance with the prescription. We noted that they were using oral syringes to measure and administer liquid medicines in line with trust policy.
- We checked 10 prescription and medication administration records in detail. We saw the pharmacist had added advice to guide safe prescribing such as including the duration of treatment for an antibiotic and correcting the dose of paracetamol. However we did not see a formal record that medicine reconciliations had been carried out. This included taking a detailed medicine history and checking prescribed medicines were correct.
- On one chart there were several signatures missing so we were not assured all medicines had been administered as prescribed. One was a medicine to be given at night. Staff explained the child was asleep at the time of the last dose. They were aware of the problem but hadn't acted to resolve it. In this case there was low risk of harm but staff agreed to review the dosing schedule to fit in with the child's day. This was brought to the attention of staff during the inspection.
- Other missing records were for creams and dressings which the child's parent sometimes applied. Staff said they may not have been made aware that the cream had been applied and so had not signed the chart. We saw a policy had been developed so that parents could be involved in the administration of medicines to their child, but it had not been followed in this case as there was no clear record of who was responsible.
- The PAU had used Patient Group Directions (PGD) in the past but some staff needed upskilling in order to use those on the PAU. This meant that children and young people had to wait for medicines such as pain relief to be prescribed by a doctor.
- PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist).

# Services for children and young people

## Records

- We looked at 14 sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- The trust used EVOLVE which was an electronic document management system which had replaced traditional hospital paper records.
- In April 2015, an audit to discover whether a child's weight was being plotted on growth charts during admission was completed. These showed children did not routinely have their growth plotted on the EVOLVE growth charts. It was reported there was a tendency to only have a growth chart on EVOLVE if they have been seen as outpatients or were under long-term care in the hospital.
- The results of this audit were shared with staff, further training on growth chart plotting was to take place and a re-audit was planned in the near future to see whether there had been an increase in the weight charts being plotted.

## Safeguarding

- According to the trust's safeguarding children annual report April 2014 to March 2015, causes for concerns processed by the safeguarding children's team had increased year on year from 5,236 in 2011/12 to 7,428 in 2014/15.
- The trust had a 'Child subject to a Child Protection Plan' (CPP) tab on its IT system which showed those children who were currently subject to or had been previously subject to a CPP.
- The trust also had an electronic safeguarding children tab which recorded a brief chronology for each child, young person or vulnerable parent/carer previously known to the safeguarding team. The information on this system was available by authorised staff 24 hours a day and all hospital consultants had access to the CPP and safeguarding tab. This enabled safeguarding concerns to be considered in the management plans for each individual child or young person.
- The NNU was a regional referral service for the Bedfordshire and Hertfordshire network and was part of

the East of England network. This meant the NNU often received babies from other areas who also had safeguarding concerns. On average there were ten cases reported per month.

- It is now mandatory for trusts to report all cases of female genital mutilation (FGM) and this was included in all levels of safeguarding training across the trust. There had been 4,989 cases reported in the UK since September 2014 with LDUH having reported 27 cases in the same time period.
- As at 30th November 2015, 86% of children's nursing staff had up to date training in adult safeguarding and 99.5% had training in safeguarding children levels one and two. 41% of nursing staff had training in safeguarding children level three. Only 65% of medical staff had training in adult safeguarding and 73% had safeguarding children training levels one and two. 100% of medical staff were trained to safeguarding children level three. The trust's internal target for this training was 80%. Were we told by staff that the 73% target was due to long term staff sickness.
- The trust told us that within the paediatric wards all band 7 nurses had received safeguarding children level three training. This meant that on every shift the senior member of staff had been trained to the appropriate level for their role in line with national guidance set out by the Royal College of Paediatrics and Child Health (RCPCH 2014). This was checked by the matron when signing off the roster each month.
- At the time of our inspection, the trust did not have processes in place for formal individual safeguarding supervision but this took place in group settings.
- Staff we spoke with could describe what types of safeguarding issues they may see and knew how to report a safeguarding concern to their line manager.
- In the CQCs Children and Young People's Survey 2014, the trust performed about the same as other trusts for safeguarding and feeling safe in the hospital.

## Mandatory training

- Mandatory training for the children's services overall compliance was 90% with conflict resolution being the only area across both paediatrics and the NNU to be less than 20%. We saw posters and notes on the safety thermometers asking all staff to make sure they completed their E learning for conflict resolution.

# Services for children and young people

- Trust data showed mandatory training compliance for paediatrics was moving and handling 84%, infection control 87%, fire safety 89%, information governance 83% adult safeguarding 86% and child safeguarding 100%.
- For the NNU, moving and handling was 89%, infection control 81%, fire safety 80%, information governance 80% adult safeguarding 86% and child safe guarding level one and two 99%.

## Assessing and responding to patient risk

- The service participated in the multi- centre international paediatric S.A.F.E project which looked at increasing the effectiveness of the PEWS and situation, background, assessment and recommendation (SBAR) tools via huddles and human factor training.
- There was a morning medical ward round where the priority was on reviewing and managing acute patients making sure they were stabilised and had a treatment and management plan. Patients that had not received a consultant review the previous night were identified and reviewed and consultants would review the sickest patients first and then new patients not already seen. All in-patients including chronic patients received a daily consultant review.
- There were three medical handovers every day attended by the consultants. Any un-well patients or those with a high paediatric early warning score (PEWS) were escalated to the consultant for urgent review.
- We observed medical handovers which were comprehensive and very attentive to patient's needs.
- Staff used 'closing the loop' ward rounds. Once the ward round was completed each case was reviewed to check what had been agreed and a plan of action was put in place. Nursing staff told us this was a very different way of carrying out a ward round and gave them the opportunity to contribute to the child's treatment and care. They told us it empowered them to participate and speak up on ward rounds.
- There was a "deteriorating child and young person" best practice document which included criterion that all patients must have a PEWS and if a patient triggered a score of three or above there should be a documented record of escalation. In addition all patients receiving high dependency care should have three documented senior reviews within a 24 hour period.
- A recent audit carried out in September and October 2015 against these standards demonstrated good compliance overall. In 100% of charts there was a clear indication of frequency of observations, 95% of patients had an age appropriate chart, 85% of the charts had dates and times clearly written and 90% of the patients were reviewed at least three times in a 24 hour period.
- The audit noted there was a need for better documentation by nursing staff regarding escalation/ action taken when a patient had triggered the score and a further audit was planned to review progress. Although there was a lack of consistent escalation documentation we were told by staff that 95% of the patients who triggered the PEWS were reviewed by senior nursing or medical staff following a verbal request.
- Whilst children were escorted to theatre by a paediatric nurse and a play specialist and once recovered from the operation were escorted back to the ward by a paediatric nurse, there were no paediatric trained nurses in the theatre complex. This meant that children did not have a paediatric trained nurse in the theatre suite.
- However all staff in recovery had paediatric intensive life support (PILS) training. There were four consultant anaesthetists with paediatric APLS training and all children's lists had two anaesthetists to provide anaesthetic cover.
- We saw staff in the NNU using hourly monitoring charts in order to recognise the deteriorating child. There were three charts used. The first was for neonates who were intubated (a tube in the throat to help them breathe whilst on a ventilator), the second for those having nasal continuous positive airway pressure (CPAP) and the third for those having spontaneous ventilation of air (SVAl ) or nasal cannula for providing oxygen.
- There was a live central monitoring system which was used by the shift leader to review all vital signs on neonates across the NNU.
- Shared learning from high dependency activity and paediatric Intensive Care Unit (PICU) retrievals was presented at the bi-annual Children's Acute Transport Services (CATS) Outreach learning days. These were attended by a multi-professional team including paediatrics, ED, anaesthetics, neonatology and other specialities to ensure the deteriorating child would be captured early.
- The learning from these days was distributed via a teaching lead to make it available for those unable to

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attend. The HDU Annual Report was also circulated to the directorate. There was a teaching programme led by a teaching lead which had a programme including mortality and morbidity.

- The paediatric team participated in Hospital Schwartz rounds which addressed the impact of difficult situations on individuals and teams. We were told by staff these had been a helpful forum to share challenging cases.
- The NNU team had a regular mortality meeting, with minutes produced, and an Annual Mortality Report dated 2013/14. The 2014/15 report had yet to be published.
- The EMBRACE report published in October 2015, based on 2013 data, had reported the service to have more than 10% lower mortality in comparison to the average for similar trusts Embrace provides 24 hours a day seven days a week, critical care transport service for critically ill neonatal and paediatric patients.
- The service continued to monitor its mortality rate and from January 2015 to December 2015 and there had been 18 deaths from various areas across the trust. Four of these had been unexpected deaths with the remaining 14 being expected.
- We saw the service had a mortality review template tool used routinely in the NNU. Paediatrics followed the Child Death Overview Panel (CDOP) process. The service had plans to implement the NNU tool for paediatrics during 2016 for consistency of process. This would be based on the Royal Children's Hospital, Melbourne Australia Mortality Review tool 2010.
- Urgent actions were initiated prior to completion of a full child death review and investigation to reduce the risk of recurrence. Formal reporting was via the Divisional Board and Clinical Outcomes Board and monitored via the Children's Board.
- Incident reports were completed for all unexpected deaths and all child/infant deaths at the trust were notified to the CDOP which was hosted by Bedfordshire Clinical Commissioning Group (CCG) for Luton and Bedfordshire CCG.
- Unexpected deaths were discussed at urgent CDOP panels usually the next working day following the death wherever possible. The panel was multi-agency and any immediate concerns or actions would be fed back to

organisations by the panel chair and organisational representative. A member of the safeguarding team as well as clinicians involved in the case would also be included in the feedback.

- Reviews of patient records were carried out to fulfil the needs for CDOP and to ensure identification of any immediate learning or clinical concerns relating to the case.
- The trust has also introduced a mortality review tool on 1 November 2015 for all hospital deaths to be reviewed by a consultant within two weeks, and the review to be sent to the medical director who would provide a summary report for the Mortality Board and share the common themes and learning with the consultant body. These reviews were also expected to go through speciality governance processes.
- Examples of learning arising from these deaths included consideration of the appropriateness of transfer for some neonates and reviewing the use of adrenaline at 24 weeks for low blood pressure.
- The service also had paediatric quick reference cards used by all clinical staff which included age-related normal values for observations to support the early identification of patient risk, advanced paediatric life support (APLS) algorithms and resuscitation drug dosages for safe and accurate emergency prescribing. We saw staff wearing these on their uniforms.

## Nursing staffing

- The service used the Royal College of Nursing (RCN) guidance on staffing levels and professional judgement to review its staffing levels in 2015 which resulted in the establishment figures for 2015/16 being uplifted by 9.63 whole time equivalent (wte) nurses. The service was actively recruiting new staff in order to become compliant with the RCN staffing levels.
- During the inspection, the wards we visited had appropriate staffing levels to meet patient's needs. Escalation systems were in place to ensure any staffing shortfalls were assessed and cover arranged. Temporary staff were supported via effective induction processes.
- For September 2015, the Women and Children's Directorate used 0.71% of agency staff, 8.65% bank staff with a total of 9.36% of agency and bank staff. For 2015 the use of agency staff never went above 1% and use of bank staff was on average 8%. We saw an induction checklist for bank and agency staff to go through before working on the wards.

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- Overall the nursing establishment figures were: trained staff 80.24wte with an actual figure of 71.91 wte and untrained staff was 20.28 wte with actual figure of 23.57 wte.
- Squirrel Ward had 17 beds with an establishment of 20.87wte uplifted to 23.66wte. The new skill mix was 79% trained nurses and 21% health care assistants (HCAs). Both the day and night shifts had four staff which equated to which was in line with trust guidance and actual staffing on inspection met the planned staffing levels according to the rota.
- Rabbit Ward had 17 beds with an establishment of 22.75wte uplifted to 24.58 wte. The new skill mix was 69% trained nurses and 31% health care assistants (HCAs). Both the day and night shifts had five staff and actual staffing met the planned staffing levels according to the rota.
- Hedgehog Ward which was a day care facility had 15 beds with an establishment of 5.95wte uplifted to 7.14wte. The new skill mix was 91% RNs and 9% HCA. The day shift had two trained staff which equated to 0.48wte to one bed ratio which did not always meet the guidance but as the ward experienced low occupancy levels the risks to patients was mitigated.
- The PAU had five beds with an establishment of 9.51wte uplifted to 10.55 wte. The new skill mix was 100% trained nurses and both day and night shifts had two trained staff which equated to 2.17wte to one bed ratio.
- There were two paediatric nurses on PAU from 7.30 am to 8 pm with another paediatric nurse from 19.30 to 8.00am
- The uplift permitted the Band 7s to become supernumerary giving greater support and supervision to the staff as well as prompt response to the bleep holder.
- From October 2014 to December 2015, the use of agency for the service was 5% and bank staff 7%. There was a nursing pay overspend of £74k for the NNU due to failure of vacancy savings and increasing spend on bank nurses. There had been a delay in recruitment of overseas nurses to cover vacancies However; there had been a reduction in the vacancies to six.
- The NNU had 98.73 wte with 89.08wte trained staff and 9.65wte untrained staff.
- We observed nursing handovers across the wards and children's areas these included the number of new

- patients, all sick children's PEWS scores, pain scores, staffing levels, numbers of children in each ward area, HDU patients, and specific safety checks carried out, education / revalidation and safe guarding.
- This was a standard form and was used across the whole paediatric and NNU services.

## Medical staffing

- The trust had a higher proportion of consultants (46%) compared to the England average of 35% and a lower proportion of junior doctors (3%) compared to the England average of 7%. The trust was in line with the national figures for medical staffing. From October 2014 to December 2015 the overall agency staff usage was 5.6% and bank staff was 7%.
- Paediatric medical cover for Monday to Friday 9 to 5pm was made up of three consultants covering the two wards and PAU. The attending consultant was onsite until 10pm then on call until 8.30am
- Two middle grade doctors (ST4+) and two junior doctors would cover between 8.30 am and 9.30 pm. One middle grade and one junior doctor overnight.
- At weekends two consultants would be onsite between 8.30am and 14.30 pm. The consultant on call was on site until 5 pm and then on call. There were also two middle grade doctors and two junior doctors each 9am to 5 pm then one middle grade and one junior doctor for the rest of the evening and overnight.
- Minutes from the Women and Children's Executive Board Meeting on the 13 November 2015 noted there was a medical pay overspend of £92k which was due to locum cover for vacancies, two maternity leave and one long term sickness. The minutes also noted locum cover would be required for any continued gaps in the medical rota.
- The middle grade rota had two vacancies which had been recruited into. We were told by staff that these posts would be filled before March 2016.
- The NNU complied with the British Association of Perinatal Medicine (BAPM) 2010 standards, independent from general paediatrics. There was an average of 20.9 hours a day consultant presence, Monday to Friday 8.30 am to 9.30 pm on the NNU. There was also a consultant presence on the unit 8.30pm to 9.30 am six days a week
- At a weekend there was a consultant presence from 9.00 am to 3.00 pm.

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- There were eight ST3 doctors to cover tier 1 neonatal unit, nine doctors to cover the tier 2 neonatal rota with an additional cover six consultants and one associate specialist.
- Tier 3 on call was provided by seven consultants (6.7wte).
- The service was not meeting the quality standard for 14 hour consultant review of all admitted patients. We were told this was due to the documentation of consultant review not always being captured. To improve audit of this standard the service had introduced a “consultant review stamp” with consultant name, date and time. This was to be re-audited in the near future to show improvement.
- For the PAU, there was paediatric acute consultant cover from 9.00 am to 5 pm with the remainder of the time covered by the consultant on call on the children’s wards. There was a designated paediatric registrar from 9.00am to 10.30 pm and from 10 pm to 9.am a paediatric registrar would cover the PAU along with the paediatric emergency department.
- Treatment by all staff including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines.
- Policies and procedures were in line with national guidance and were easily accessible on the intranet.
- Patients’ pain was addressed and national nutritional tools were used to monitor those children who may be at risk of malnutrition.
- The service took part in national research programs and used the outcome of these to develop innovative and pioneering approaches to high quality care and monitored the safe use of these new approaches.
- The service participated in benchmarking, peer review and accreditation and was obtaining good-quality outcomes as evidenced by a range of national audits such as the Royal College of Paediatric Child Health (RCPCH) National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA).
- The Neonatal unit (NNU) was the lead unit for Hertfordshire and Bedfordshire since 2003 and its high performance was recognised by external bodies.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued.
- Both medical and nursing staff had access to education, training and development and staff felt supported in delivering high quality care. The service had developed and provided courses such as children’s assessment knowledge and examination skills (CAKE) courses and STABLE courses for staff which was accessed by external organisations. These had been accredited by the RCN, RCPCH and the local university.
- Patients were at the centre of the service and the main priority for staff. Staff were continually updating their skills and competencies and were proactively supported to obtain new skills and share best practice.
- There were a range of Clinical Nurse Specialists and Advanced Nurse Specialists who supported teams and patients in specific areas, bringing their own expertise and knowledge to develop innovative and individualistic ways of improving services.
- Staff, teams and the service was committed to working collaboratively and found innovative and efficient ways to deliver more joined-up care to patients. There was a range of examples of working collaboratively and the

## Major incident awareness and training

- The trust had a major incident plan which was available on the intranet. The trust had contingency plans for children and young people’s services which had been ratified in January 2014. These plans covered staffing, beds shortage, closure of the unit, mobile phone and lift failure.
- There was a business continuity plan dated June 2013 for review April 2016, the NNU and Paediatrics had its own contingency plans within this document.
- Staff was aware of their responsibilities in the event of a major incident and knew about their roles.

## Are services for children and young people effective?

Outstanding



Overall, we rated the service as outstanding for effectiveness because:

- There was a holistic approach to assessing, planning and delivering care and treatment to patients.

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service used innovative and efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge, transfer or transition to other services.

- The service prided itself on meeting the transitional needs of young people living with chronic conditions or disabilities through engagement with adult and community services to improve transition from children and young people's services to adult services.
- The systems used to manage and share the information that was needed to deliver effective care were fully integrated and provided real-time information across teams and services.
- Consent practices and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.

## Evidence-based care and treatment

- The service had a range of policies in place based on the National Institute for Health and Care Excellence guidelines. Staff demonstrated awareness of these policies.
- The trust took part in the RCPCH Epilepsy 12 national audit in November 2014, which resulted in actions needed to be taken such as: developing a database for children living with epilepsy, recruiting an epilepsy nurse specialist, identifying the number of children that would require referral to a tertiary centre alongside the number of children referred and not referred.
- The service participated in the NNAP which was published in November 2015 and reported on data from 2014. There were a number of actions for all trusts across England which they were addressing. The service also took part in the National Diabetic Audit 2013/14.
- The NNU was also taking part in the 'first hour of care project' which was an East of England approach to the first hour care for babies and would ensure all babies received the same care and management.
- Staff were very proud about their cooling service which they had developed and continued to deliver. NICU had a protocol to follow which allowed them to cool a baby to 34.5 degrees and scan the baby at one week to check if there was any brain damage.
- The NNU used an Early Onset Sepsis Care Bundle which was implemented within the NNU in December 2015. This included the risk factors and clinical signs of sepsis and if the neo-natal baby scored one red flag or two amber flags a sepsis screen would be performed.

- Staff told us the care bundle was currently being embedded into practice and an audit was planned for April 2016 when the care bundle would have been in use for three months.
- The service was UNICEF baby friendly level 2 accredited. The baby friendly initiative awards were based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. These were designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways, which will support optimum health and development. Facilities implement the standards in stages over a number of years. At each stage, they were externally assessed by UNICEF UK. When all the stages were passed, they were accredited as Baby Friendly. Award tables are kept to let the public know how facilities are progressing.
- The team used the Bayley Scales of Infant Development (Bayley-III) tool which was an internationally recognised tool to assess children from as young as one month old and would be used at intervals until the child reached the age of two years.
- There were four nursery nurses who supported parents and staff with play opportunities for children and young people.

## Nutrition and hydration

- The service used the Paediatric York Hill Malnutrition Score (PYMS) which was a means of identifying neonates and children and young people who were at risk of malnutrition. These scores were checked daily by the dietician and where there were concerns this would be flagged up to medical and nursing staff for action to be agreed.
- The service undertook monthly paediatric nutritional audits. For example the paediatric service for October 2015 scored 100% for responses to the questions: "Has the child been offered food? Did the child receive appropriate foods based on their cultural & physical needs? When asked did the child feel they had enough food?".
- The service participated in East of England nutrition care pathway which had received national recognition for its innovative approach to parental nutrition.

## Patient outcomes

- The NNU had a summary report for January 2015 to September 2015 which demonstrated the service was

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performing much better than the national average for temperature recording (100%) with a national average of 91%, all babies under 1.501 kg undergoing retinopathy (98%) national average 90%, babies less than 33 weeks receiving mother's milk on discharge (70%) national average 59% and documented consultation with parents by a senior member of the neonatal team (96%) national average 86%.

- Whilst the NNAP standard for screening for retinopathy was 100% the NNU showed one infant being screened outside the national standard. Medical staff told us this was due to the condition of the infant and screening could not take place due to the baby being too ill. Retinopathy is a non-inflammatory disease of the retina which may be found in premature babies.
- The NNU had been involved in the original trial (The TOBY trial) of cooling babies to treat asphyxia and was now one of three centres in the East Anglia to provide this therapy. Cooling therapy is used when a baby is deprived of oxygen at birth and improves their clinical outcomes and chances of growing up without disabilities such as cerebral palsy.
- Improvements had been seen with 27% of patients having an HbA1c of less than 58mmol/mol compared with 21% in 2013/14 and the mean HbA1c of 73.0 was now 67 and was better than the England average of 71.6. At the time of our inspection the trust was awaiting the 2014/15 annual results.
- Following the RCPCH Epilepsy 12 national audit there was now an epilepsy nurse in post and a database for children living with epilepsy.
- The service participated in the National Diabetic Audit 2013/14 and performed better than other trusts. For example, when asked if the diabetes team gave helpful advice the trust achieved 78.6% which was better than the England average of 62%. Also when asked if there was an opportunity to provide feedback about their care and treatment the trust scored 61.5% which was better than the England average of 43.7%.
- The trust had an annual audit plan and took part in the 2013/14 NPDA. The results from the audit showed that 21% of patients had an HbA1c of less than 58mmol/mol (indicating controlled diabetes) compared to an England average of 18.5%. However the trust reported a mean HbA1c of 73.0. This was worse than the England average of 71.7 HbA1c levels are an indicator of how well an individual's blood glucose (sugar in the blood) are controlled over time.
- Following the publication of the NPDA audit, the hospital diabetes MDT met to review and discuss the results. An action plan was drawn up to review and manage provision where the local service was not performing as well. For example the service had a low percentage of urine albumin estimation. An action was put into place for all patients to have urine analysis, along with height and weight. Over the last year the paediatric diabetes nurses sends an automatic text reminding patients of the appointment and the need to bring a urine sample.
- Between July 2014 and June 2015, the multiple readmission rates for asthma patients aged 1-17 years old was 14.6% which was better than the England average of 16.8%.
- The women and children's service monitored readmission data as part of the CCG data pack and reviewed admission of children with long term conditions with its open access policy. The service had been commissioned by Luton CCG to work with local GPs to review pathways and put in place local access passports for children living with chronic or complex needs identifying primary care management expectations (especially for routine illness) and clear criteria for open access for condition specific review.
- Paediatric readmission within 28 days was reviewed and monitored against the trust standard to offer parents 24/48 hour open access following attendance at PAU or discharge from the unit. Parents were advised to ring PAU to discuss concerns prior to re-attending if necessary.
- Hospital Episode Statistics (HES) data June 2014 to May 2015 showed the service had higher readmissions after elective Ears, Nose and Throat (ENT) surgery, admissions for 1 to 17 year olds and emergency admissions after a paediatric admission for 0 to 17 years.
- We were told readmissions for ENT have not been specially highlighted as a local concern for the ENT surgical team and when using other national analysis such as Dr Foster data this showed the service to be within the relative risk thresholds. The ENT surgical team was also the out of hours receiving centre so readmissions were higher overall for the service. The service continued to monitor this data carefully and had seen an improvement since May 2015.
- The multiple readmission rates for epilepsy patients aged 1 to 17 years old were 40.5% which was worse than the England average of 27.8%.

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- The service had analysed this data which showed these primarily related to children with complex epilepsy and or additional health co morbidities. Not all admissions were related to seizures with many relating to infection.
- The paediatric epilepsy service was well established and understood the population needs and recognised the higher than national average admissions and readmissions.
- Of the 43 children cared for by the paediatric epilepsy service, 37 had complex epilepsy with several co-morbidities where the seizures were not always controllable or predictable. These 37 patients were expected to have unpredictable seizures particularly at times of being unwell.
- 28 of these children had access to an epilepsy nurse specialist. The service did not have data to show how many of these hospital admissions were prevented. Some of the patients with high numbers of admissions had access to specialist nurse support.
- Work had been carried out with Luton primary and community services to develop and implement a patient passport looking at the individual needs of the child. For epilepsy this included their rescue regime as appropriate with a view to ensuring parents, community teams and primary care knew and understood the needs of the child.
- The multiple readmission rates for diabetes patients aged 1 to 17 years old were 24.5% which was worse than the England average of 13.6%.
- We were told there had been a year on year increase in cases of type one diabetes identified, many of which were still coming into secondary care very unwell.
- The service had analysed its data which showed out of 110 admissions only 43 were primarily related to diabetes. Some of these admissions were short and enabled treatment for hyper/hypoglycaemia as well as reassurance for children, young people and their families. Some of the multiple admissions were children with other complex health care needs and were primarily due to other reasons such as infections, elective surgeries, planned antibiotics in a child with cystic fibrosis and admissions due to psycho –social reasons.
- Training had been provided on the best way to position babies and a further audit in October 2015 was carried out to see if this had improved. Positioning is important for babies born early as they lack muscle strength so

- aides such as gel packs and special beanbags need to be used to help the baby replicate being in mother's womb and give chance for the muscles to develop normally
- The results showed improvements had been made and the overall positioning score had improved from 24 out of 30 in March 2015 to 28 out of 30 in October 2015. The results were displayed on the developmental care information section of the NNUs quality and safety board and at safety briefings.

## Pain relief

- The service adhered to the Faculty of Pain Medicine's Core Standards for pain management by undertaking a monthly audit. Ward staff retrospectively reviewed ten sets of children's clinical records for a number of audit criteria including pain.
- The data submitted from October 2015 to December 2015 had been reviewed and resulted in pain being assessed and documented in 100% of the notes audited. Medication had been offered/administered in 75% of the patients with one patient having only a small amount of pain therefore did not require analgesia.
- In those patients that required medication they received it quickly. Most of the notes reviewed as part of the audit identified that the pain criteria were not applicable to paediatrics as analgesia was not required more than once so the criteria was rated as not applicable . The results showed the wards could improve on recording of the impact of pain relief and were reported back to matrons and ward staff and overseen by the Nursing Quality and Performance Meetings.
- The service also carried out monthly pain audits across paediatric care. For October 2015 paediatrics scored 100% for the questions 'Was the child severity of pain recorded' and 'When the Child was documented as being in pain, was pain relief administered'.
- We saw one occasion where a child had been given analgesia and child's pain was rechecked to see whether it was effective or not. This proved to be effective.
- Paediatric services used two types of pain scoring tools, a face, legs activity, cry and consolation (FLACC) tool used for children up to four years of age and the Wong's face tool of 0-10 faces for children from five to 12 years of age.
- The NNU did not use a recognised NNU pain scoring tool which was similar to other NNUs across the East of England Neonatal Operational Development Network.

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NNUs across the East of England network were working together to develop a single pain scoring tool that would be used to benchmark the management of pain in a more consistent manner.

- For the CQC children's 2014 survey the trust scored 80% which was similar to other trusts for parents believing that the hospital staff did everything to help ease their child's pain.

## Competent staff

- Appraisal rates were 90% within the paediatric areas.
- All 15 consultants had revalidated and the service had monitoring processes in place to ensure consultants were supported through their revalidation periods
- All nurses working with acute inpatients undertook a one day (7.5 hours) Intermediate Life Support (ILS) training bi-yearly, alternating with a half day (3.5 hours) refresher in between. The ILS training included; observation management, escalation procedures, emergency department patient assessment, Basic Life Support (BLS), cardiac arrest management, defibrillation, situation, background, assessment and recommendation (SBAR) communication and work based relevant scenarios. 75% of staff were also trained in advanced paediatric life support (APLS) which was similar to other trusts
- Due to the increase in HDU activity 15 nurses had now been trained to HDU level.
- All preceptor nurses received a one day acute life threatening events recognition and treatment (ALERT) training and all HCAs received a Bedside Emergency Assessment Course for Healthcare support workers (BEACH) course on induction.
- There was children's assessment knowledge and examination skills (CAKES) course which was accredited by the Royal College of Nursing (RCN) and RCPCH and took place three times a year. This was a multi-professional educational course which ensured competency/confidence of staff in all settings to recognise sick children needing urgent hospital treatment and appropriately assess/manage children safely outside-of-hospital settings and at home. This had been developed by the PAU staff.
- The NNU had two advanced neonatal nurse practitioners (ANNP) who covered the post-natal unit, delivery suite, and the NNU. They worked at a senior house officer level and were part of the medical rota. One of the ANNPs ran the sugar, temperature, airway,

blood pressure, lab work emotional support (STABLE) programme at the local university three to four times a year. This programme had been opened to the East of England Neonatal Network. Part of the ANNPs work was to support colleagues, senior nurse and medical staff within the clinical areas. Staff on the NNU attended the STABLE course as a development opportunity.

- Nursing staff attended study days provided through the East of England Network and all specialist nurses we spoke with told us they kept up to date through their on networks.
- We spoke with three nurses in training on the paediatric wards who told us the support they received was 'fantastic'. They all had received induction, had been given a mentor and competency frameworks for their area of work.
- We spoke with three newly appointed nurses who were extremely happy with the support they received by their mentors. They told us their mentors were easily accessible, spent time with them explaining each child with them and what plans there were to care for each child. They felt confident they could go to their mentor if they were unsure about what they had to do.
- Two junior doctors told us this was the second time they had worked in the NNU as they had learned so much at the previous placement.
- All HCAs received annual refreshment on statutory training combined with their BLS session which included monitoring, escalation protocols and recognition of the sick patient.
- Junior medical staff told us they felt very supported by all staff and were given an allowance of £700 per year for career progression and development and were given time off for exams.
- In the 2014 CQC Children and Young People's Survey, the trust scored 74% for the question (asked to parents of children aged 0-15 years): "Did you feel that the staff looking after your child knew how to care for their individual or special needs?" This was worse than other trusts.

## Multidisciplinary working

- There was a range of multi-disciplinary team (MDT) working for instance the epilepsy MDT meetings where new patients and children diagnosed with epilepsy were discussed on a weekly basis and MDT records kept in the patient notes. There were also MDT meetings with neurophysiology to discuss difficult diagnostic cases.

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- There was MDT support for children and families with diabetes, chronic conditions and a group for children with chronic abdominal pain.
- Whilst the pharmacist did not attend daily ward rounds they would work on the ward each day. We saw evidence via medication charts that suggested the pharmacist did attend daily, checked all drug charts, and completed monthly drug errors reports. We were told the pharmacist also attended the grand rounds to discuss the medication errors.
- Dieticians attended a weekly ward round and gave targeted input where necessary.
- Over the last 18 months the service had been working with the Child and Adolescent Mental Health Service (CAMHS), which was provided by another NHS trust, up to and including age 17 years to streamline and improve the process for children and young people who were admitted to hospital and required a review by specialist mental health teams. This had resulted in the redesign the process of how children were referred, reviewed and supported in a safe and timely manner.
- There was a multi-disciplinary child and adolescent mental health pathway which was used to ensure any child attending the trust followed the correct pathway. Information was shared so that the most appropriate support was given for this group of patients. This resulted in the joint development of new care plans and guidance for staff in gaining 1:1 support received by patients who needed close supervision to maintain their safety and the safety of others on the ward.
- The trust had a paediatric liaison psychology service and a named paediatric liaison psychologist and provided support for children living with a mental health problem.
- Children admitted with an eating disorder were managed jointly by the paediatric consultant and a specialist nurse from CAMHS. There was 24 hour support provided from a registered mental health nurse (RMN) when required and we saw this was happening with one patient at the time of our inspection.
- Paediatric consultants were working with adult services to develop transition clinics. Children were invited to attend adult clinics at their 15th birthday so they were given time before being handed over to full time adult care.
- The service had a transition checklist which was adapted from the Adolescent Health Transition Project 2014 and was used to ascertain a child's knowledge of their condition, medication, implication of their condition and whether they knew who their specialist doctor and nurse were.
- Transition clinics were already available for diabetes, inflammatory bowel disease, epilepsy cystic fibrosis, primary ciliary dyskinesia, severe asthma, other respiratory diseases, complex gastro-intestinal diseases, HIV, oncology, endocrinology and those children requiring nutrition support such as enteral feeding.
- Staff told us young people living with diabetes were considered for transition at 15 years of age dependant on their developmental maturity and preference, Once agreed they were booked into the diabetes transition clinic run by a MDT team of a consultant paediatrician with interest in diabetes, a paediatric diabetes specialist nurse and a dietician.
- Young people at 16 to 18 years of age living with chronic endocrine problems were seen jointly by the paediatric endocrinologist and the adult endocrinologist. The clinics were based in the children's outpatient department.
- There were specialist nurses in both paediatrics and adults who were actively involved in the transitional process.
- The NNU had its own neonatal physiotherapist who worked closely with the nursing and medical staff and with parents for those children born under 32 weeks gestation or under 1500 grams and children having cooling or nitrous oxide therapy.
- The physiotherapist would be alerted to a new baby to the NNU meeting the above criteria and would visit the parents and baby once they had settled into the NNU. The physiotherapist would work with the parents and staff in ensuring the baby was positioned correctly using gel packs and special beanbags.
- The physiotherapist undertook a direct observational audit of nurses and parents positioning of the baby in March 2015 which showed overall nurses and parents were using positioning equipment so that babies were positioned in such a way as to enable their physical development to match that of being in the womb, with further work needed to improve good shoulder positioning.
- With parents' consent the physiotherapist also took videos over a twelve week period to demonstrate the babies' development. Longer term the physiotherapist

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would attend development clinics with consultant paediatricians, community physiotherapists and paediatric nursing staff in order to continue any support that was necessary in the babies' development.

- The service had a child centred multi-agency approach to the care of children and young people in their last stages of life with four main providers of end of life care working together across Luton, Cambridgeshire community services, Keech children's hospice, LDUH and Luton Borough Council.
- There were three pathways of care used across the service; the neonatal and stillbirth pathway which was still in development, the palliative care core pathway and the transition pathway. In addition there were a wide variety of support services such as occupational therapy, continence services CAMHS and young carer support service used to support children and young people.

## Seven-day services

- Paediatric physiotherapists were available Monday to Friday from 8.15am to 4.30 pm and covered the three paediatric wards along with the PAU. An on call service was provided at weekends which covered both adult and children's services.
- Pharmacy provided a full weekday service from 9.00 am to 5.30 pm with a dispensary service available at weekends 10.00 am to 3.00 pm Saturdays and Sundays. This was a two person clinical service and there was access to an on call service out of hours.

## Access to information

- Staff told us they had individual email accounts and information was shared with staff through emails, newsletters, staff meetings and handovers.
- Medical staff told us there were protocols on the trust's intranet which were reviewed regularly, were well written and easy to follow.
- In the CQC children's and young people survey 2014 the trust scored 66% which was worse than other trusts (80%) for the question relating to staff being aware of the child's medical history.
- Discharge summaries were sent to GPs via an electronic discharge letter.

## Consent

- There was a trust policy for consent to examination or treatment dated September 2012 to be reviewed in 2016

- which included 'children under 16 – the concept of Gillick competence,' Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own ,medical treatment, without the need for parental permission or knowledge.
- In the 2014 CQC Children and Young People's Survey the trust scored 86% for the question (asked to parents of children aged 0-15 years): "Did a member of staff agree a plan for your child's care with you?" This was consistent with other trusts and we saw examples of care plans being signed by parents.
- The service was part of the trust wide consent to surgery audit in 2015 which found 100% compliance with the appropriate consent form being used. There were some areas where improvement was needed such as the job title of the healthcare professional was missing and abbreviations were used. Actions had been taken to improve these areas.
- We saw consent forms were used appropriately and were fully completed.

## Are services for children and young people caring?

Good



Overall, we rated the service as good for caring because:

- Patients were at the centre of the service and the highest quality care was a priority for staff.
- The parents we spoke with told us their children were treated with dignity and respect and had all their care needs met by kind and caring staff that went the "extra mile." Feedback from all parents we spoke with all spontaneously mentioned how positive their experiences had been.
- The service was responsive to children and young people's needs. Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased.
- All people we spoke with were positive about their child's care even when the outcome was not a good one. Cards and comments displayed across the service, without exception, told of the kindness and care their children had received.

# Services for children and young people

- The level of information given to parents was often complex and staff managed to communicate with the parents in a way they could understand and took their time to ensure parents understood what was being said. This was the same for parents visiting older children on the paediatric wards.
- Parents were encouraged to take part in the daily ward rounds so they understood the decisions being made about their children.
- The service took the 2014 Friends and Family Test seriously and from the results of the test had comprehensive plans in place and had made significant changes and improvements through carrying out and acting upon its own patient surveys.

## Compassionate care

- We observed children and young people being communicated with by nursing and medical staff in a compassionate way. Curtains were drawn around patients to ensure privacy and dignity and voices were lowered to avoid private and confidential information being overheard.
- The response rate for the Friends and Family test for the trust was 18.2% and 95% of parents had responded to the question they were likely to recommend the service to their friends and family.
- The service had implemented a number of actions since the survey such as making 'take home' drugs more available to speeding up discharge from the ward, embedding 'My Daily Plan' to improve communication and to encourage sharing of questions, improving the play room by having longer hours and more activities for teenagers in the evening.
- All parents we spoke with spontaneously mentioned how caring staff were. Parents told us the service was 'brilliant' and 'everything is awesome'.
- Cards and comments displayed on the department, without exception, told of the kindness and care they had received.
- As part of one child's holistic care when admitted to the ward, a child's dog came along and accompanied the child during the procedure whilst they were awake. Once asleep the dog's working harness was removed staff took him on a tour of the wards so other patients were allowed to pet him. This meant the child's ward

admission and procedure went smoothly, the child felt safe having their dog with them and the parents stress was also reduced. Staff told us the other children on the ward enjoyed seeing the dog.

- The atmosphere on the NNU was calm and professional and nurses were observed talking to patients and explaining their care and taking their time to ensure parents understood what was happening to their child.

## Understanding and involvement of patients and those close to them

- Parents were involved with their child's care and decisions taken. We saw evidence in the clinical notes that patients were involved in making decisions about care and treatment. Children were involved in their care whilst going through the care planning process with their parents.
- We saw the paediatric wards had 'my daily plan' at each bedside which was used as a communication plan and gave parents the opportunity to write their concerns or thoughts so staff could discuss with them when necessary. Parents told us this worked well and was responsive to their children's daily needs.
- Parents told us staff went the extra mile to ensure they were kept up to date on their child's care and treatment. Three parents told us how staff would contact them at home if necessary to keep them up to date. One parent told us how they worked with the dietician to plan the meals for their child to ensure the child not only had the correct diet but they had the type of food the child preferred.
- Parents told us they were encouraged to attend ward rounds when possible so they could understand what was happening with their child or young person and they could also be part of the daily planning of their child.
- We saw parents visiting their babies in the NNU and heard staff telling them about their baby's condition and answering the parents' questions in a professional manner. Whilst the level of detail was in depth and at times complex staff managed to communicate with the parents in a way they could understand. This was the same for parents visiting older children on the paediatric wards.
- We were told by parents staff would often ring relatives during the night if necessary to keep them updated.

# Services for children and young people

- For the CQC children's survey 2014, the trust scored worse than the England average for ten out of 34 indicators relating to caring. The remaining indicators were similar to the England average.
- For example the service scored 81% for parents saying staff answered questions before their child's operation or procedure in a way they could understand and 71% for parents saying they were told what to do or who to contact if they had concerns when they got home. This was worse than other trusts.
- The service also scored 78% for hospital staff telling parents or carers what would happen to their child while they were in hospital and 78% for parents or carers being involved in decisions about their child's care and treatment. Both of these scores were similar to the national average.
- However, this was data taken from 2014 and published in 2015. In July 2015 the NNU carried out its own service questionnaire with the response to the question 'by the time I went home I felt I could manage my baby's care', the service scored 80% (strongly agreed), 'I received regular information about my babies condition' scored 78% (strongly agreed), 'the information given to me was understandable' scored 85% (strongly agreed) and 'I feel I understand about my baby's condition and why things were done' scored 95% (strongly agreed).
- The service's paediatric patient survey action plan which was updated in January 2016 showed a number of actions to be taken to improve communication with parents and children. For example, a communication sheet had been designed for use with complex patients which was to be reviewed after one month in use and parents now signed a proforma to demonstrate they understood and agreed with their child's care plan.
- A discharge checklist had also been developed in order to ensure pre-discharge information was appropriate and was to be audited at a later date. Further training was being delivered to junior medical staff on the importance of good communication with patients, parents and staff.
- There were now 'you said we did' boards and 'help our service grow' trees which would give parents more opportunities to raise concerns and give feedback during their child's admission. These could be found in the play room, the parent's room, outpatients and the emergency department.
- Parents told us that they considered their children's privacy and dignity had been maintained throughout their stay in the service.
- Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviours.
- Staff ensured parents accessed information leaflets on clinical conditions which were widely available throughout the service.
- There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both children and parents.
- There was a range of specialist bereavement services available when needed such as an oncology nurse to support families of children with cancer. Parents and children and young people could also access support through the services arrangements with Keech Hospice. Following a child's death families could use the Meadow Suite at Keech Hospice even if they had not previously used the hospice's facilities.
- Staff told us if there had been an unexpected death families were supported by the CDOP team specialist nurse, with the opportunity to meet with trust staff. Families of patients previously known were routinely offered follow up by their own consultant.
- We saw two pictures a young person had drawn when they had been told they would need a permanent tube into their stomach. The first was a picture of a broken heart; the second at a later date was a picture with a heart mended. The young person could only describe how much better they felt once staff had supported them through the period prior to the procedure being performed and afterwards. Children also had access to counselling when needed.

## Are services for children and young people responsive?

Good



Overall, we rated the service's responsiveness as good because:

- There were a range of examples of how, as an integrated service, children's services were able to meet the complex needs of children and young people.

## Emotional support

# Services for children and young people

- The service involved other organisations and there were examples of local community being integral to how services were planned and ensured that services met children and young people's needs.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The use of open access and passports were examples where children and young people could gain access to services in a way and at a time that suited them.
- The service prided itself on the low number of complaints it received however when a complaint was made improvements were made as a result across the service.

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

- The needs of children's services and the trust's future strategy had been incorporated into plans for the redevelopment of children's services.
- Trust plans for re-development were aimed at supporting a new and dedicated paediatric emergency department, with a co-located and enlarged PAU, This would free up capacity within the paediatric wards to support the increase in demand and provide an opportunity to redesign some areas to support service development and patient experience.
- The service was also looking at creating a dedicated adolescent unit to provide patient focused care and facilities and create a dedicated high dependency unit.
- There were plans for the new neonatal unit to provide increased capacity to support the care and return of all babies and mothers who required specialist NNU care. The unit would also support transitional care so that mothers and babies could receive dedicated care together and improve accommodation to support parents with premature babies.
- Work with Luton GPs had resulted in giving children living with a long term condition a patient passport which provided open access and highlighted the specific need for that child's long term condition. This also supported the reduction in avoidable hospital attendance for minor illness.
- The children's and young people's service had seen a steady increase in the admissions for mental health disorders primarily self-harm and eating disorders, with a significant number requiring specialist input or mental

- health inpatient care. The lack of tier four beds had been raised with local commissioners and NHS England and had been included on the local safeguarding board's risk registers.
- In August 2015, the service took part in a joint workshop with local partners to review and look at transforming mental health services. We were told by the service that the information from this event was going to be used to inform the development of local services to meet the needs and demands of the local population.
- Hedgehog Ward provided day case care and covered surgical specialities such as general surgery, ENT, orthopaedics, ophthalmology and orthodontics and was open from 7.15 am to 8.00pm.
- Medical day care was also provided for children and young people having an MRI scan via sedation or general anaesthetic, specific injections for chemotherapy and rheumatology, food challenges and blood transfusions. Every fourth Saturday Hedgehog Ward would care for children and young people living with sickle cell disease who required a blood transfusion.

## Access and flow

- The PAU provided medical assessment for children and young people. Referrals were received via a number of routes including from GP's, the urgent care centre, paediatric emergency department, midwives, walk-in centre, community children's nursing teams, children's clinics and open access.
- Of the 5,952 admissions to Pau in April 2015 to December 2015, 2,074 stayed in less than two hours and 499 stayed for more than six hours. The length of stay was dependent upon the complexity of the child's condition.
- A monthly audit of documentation undertaken in November 2015 on PAU showed 82% of children and young people were seen by a nurse within 20 minutes, 76% were seen by a doctor within one hour and 82% seen by a senior registrar or consultant within four hours. This was an ongoing audit and feedback was shared monthly with staff during one to one sessions, discussion at safety briefings and information on operating practices for medical staff.
- For those children and young people requiring a joint injection under general anaesthesia this was arranged through the Hedgehog Ward and the rheumatologists.

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- Children and young people needing elective surgery would be pre-assessed prior to surgery and would be operated upon in the main operating theatres either at the beginning of a list or at the end of a theatre list. There were no dedicated operating theatres or lists for children.
- There were two bays in the recovery area allocated for children's surgery. Although these bays could be curtained off to ensure children were not exposed to seeing adults being cared for after surgery and to maintain their privacy, these were not child friendly.
- For emergency surgery children and young people could be admitted under general surgery, ENT, ophthalmology, oral maxilla facial, gynaecology or orthopaedic and those requiring overnight/HDU care were admitted to either Squirrel or Rabbit Wards.
- The median length of stay was one day and was higher for elective admissions of patients aged under one year old.
- For patients aged under one year old, the most common reason for admission was "other perinatal conditions" followed by "acute bronchitis". For patients aged one to 17, the most common reason for admission was "viral infection".
- The service met the referral to treatment time of within 18 weeks 92% of the time since April 2012.
- Between April 2015 and August 2015, 11 children who were referred from their GP had to wait 13 weeks or more for a first attendance at the trust. Two had to wait for a paediatric cardiology consultation and nine for a paediatric medical consultation. This was under review.
- There was a dedicated children's outpatient department with a mixture of general paediatric and sub speciality clinics including regular visiting outreach consultants from tertiary hospitals working alongside the trust's own teams.
- There were 46,966 attendances where children were seen annually in all outpatients' clinics with 23,700 attendances specifically in the children's outpatient clinic. Staff told us not all children could be seen in the children's outpatients department as some clinics used specialist equipment and could not be based in the outpatients department.
- The diagnostic service had a dedicated paediatric list on a weekly basis. The appointments were longer and managed jointly by the paediatric team and diagnostic staff. Patients were able to be brought to the department with their parents and staff from the wards to ensure that they knew staff present. Diagnostic areas were appropriately decorated with children's characters to assist with them feeling comfortable.
- Outpatient clinic areas did not have any specific child areas; however appointments were fast-tracked to enable less time spent in the department. Where possible appointments were also flexible to allow them to fit around school and other appointments.
- The overall did not attend (DNA) rate for children aged 0 to 15 years was 12% and for young people aged 16-18 years was 13.5%. The 16 to 18 year old data had been collected separately as serious case reviews had shown failure to attend appointments was a factor in neglect.
- Medical staff told us they would check the DNAs at the end of a clinic and would offer a repeat appointment. They would speak with the safeguarding team if there were concerns.
- The service analysed its Friends and Family Test for the autumn quarter 2015 which showed waiting times were an area for concern. As a result waiting times were to be discussed with consultants and there was an ongoing plan in place to streamline speciality clinics.
- Bed occupancy rates for the NNU between July 2015 and December 2015 ranged from 59% to 93% with an overall occupancy rate of 80%. In the same period the NNU had accepted 138 transfers into the unit and 85 transfers out of the unit. 38 of the transfers out were due to baby's being repatriated, 47 for surgical, medical or specialist opinion.
- The service had four funded 'virtual' HDU beds which were used flexibly. Care was provided on both Squirrel and Rabbit wards according to need.
- There was a standard operating procedure in use for assessing when high dependency was needed.
- Admission to the HDU could be via the PAU, the children's emergency department, open access passports for children with chronic or complex medical needs and returning from tertiary centres.
- Elective admissions to the HDU were discussed and agreed with the consultant and ward manager which allowed for adequate and appropriate staffing levels.
- Between April 2015 and December 2016, there were 32 transfers out to a paediatric intensive care unit (PICU) by the children and adolescents transfer service (CATs)

# Services for children and young people

service. 20 were directly transferred from the paediatric wards, eight from the children's emergency department and three from the children's emergency recovery and one from the main theatres recovery.

- Medical staff told us operating theatres / recovery may be used as a holding area specifically for a difficult airway case requiring airway equipment and gases. This area may also be used if a child required a tracheostomy.
- The NNU had a sister whose post was on the unit as well as in the community. She would see all babies under two Kgs or under 36 weeks, babies requiring oxygen therapy and those babies needing naso-gastric feeding.
- Parents would be trained to administer oxygen prior to the baby being discharged home so they could be discharged home sooner. This was supported by literature for the parents to take home with them. Training also included how to use oxygen cylinder, how to recognise if the baby was deteriorating and how to carry out resuscitation if needed.

## Meeting people's individual needs

- Specialist nursing staff told us about a child living with a complex condition who required regular and highly specialised blood tests. A special panel was brought together to review how these tests were managed so as to reduce the time waiting and processing the tests. This resulted in staff looking after this child both at home and in the hospital and being able to fast track the request so reducing the time taken to carry out the tests and reducing the time the child had to spend in hospital.
- This then led to using a similar approach for those children both at home and in hospital having parental nutrition. Parental nutrition is a method of feeding a patient through the veins. Daily, weekly and monthly blood tests go through the same system, reducing waiting times and making the outcomes of the child's care and treatment more effective and timely.
- Nursing staff told us about a child who was living with a condition where regular blood samples needed to be taken. The child had a phobia to needles and trying to take a blood sample was causing the child to become extremely agitated. Staff researched what options they could use and found a piece of equipment which acted by confusing the body's own nerves and distracting

attention away from the needle being used. This resulted in the child having blood tests without being agitated and enabled the mother to buy the same piece of equipment to have at home.

- In the last 12 months, there were 136 children living with a mental health condition admitted to a general paediatric ward as there were no mental health beds available. Of the 136, 69 were children having taken an overdose, 59 self-harming and eight with an eating disorder. This was being reviewed.
- For children living with a learning disability the trust had an adult learning disability nurse who worked across the trust. We were told the majority of these children were well known to paediatric staff and would rarely use the expertise of the adult learning disability nurse. However, if there was a new child who was not known to the service they would use the adult learning disability nurse as a point of reference.
- There were links with the community learning disability nurses to ensure continuity of care. The discharge coordinator and other professionals such as dieticians, physiotherapy and speech and language therapists would also meet to discuss a child's care and treatment.
- Care plans for children living with a disability had input from their families and included play plans. Children had their own open access passports.
- The paediatric wards had a school room which was open Monday to Friday from 9.00am to 3.30 pm with two trained staff who would visit all school aged children each day to review their individual learning needs. The school room was not a registered centre for exams but staff liaised with schools to ensure some of their young people could take their GCSE's whilst inpatients. This resulted in five young people taking their GCSE's at one time with one external invigilator to oversee the process.
- The service had a play room which was open 7.30 am to 7.30 pm seven days a week. There were four nursery nurses who supported parents and staff with play opportunities for children and young people. For children and young people undergoing chemotherapy or having compromised immune systems the play room would be open for them individually when needed.
- Each child had a play plan which included the things they liked to do and things they disliked.
- Translation services were available via the patient advice and liaison service (PALS). Documents could be

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translated on request and face to face interpreting could be booked in advance. For out of hour's translation services there was a 24 hour telephone service.

Literature was available in different languages.

- Whilst the NICU currently did not have a BLISS champion the neonatal lead supported the work of BLISS and received regular information.
- The service had worked closely with BLISS and completed the BLISS audit that identified the need to improve the parent's facilities. Following completion of the audit the service had refurbished the parents kitchen provided three rooms for parents accommodation within the bungalow located close to the hospital so that parents could visit their babies in hospital. The bungalow had three double bedrooms with a personal milk fridge, shared bathroom, kitchen and garden. There were also two small parent's rooms close to the NNU for parents to stay and the kitchen had recently been refurbished.
- This was a large scheme and was supported by volunteers and fundraising to be able to provide this service. The accommodation had been very well received and the service was looking to increase the provision.
- Other changes had been made to improve the surroundings and improve the experience for parents such as cubicles being fitted with individual fridges, free parking for parents if a child was admitted overnight, the seating area had been improved and there was a TV. Parents also received breakfast if they stayed overnight with their child and mums who were breast feeding were provided with food at meal times.
- We saw lunch being served on the paediatric wards which looked appetising with a good variety of choice. There was a choice of hot and cold food including lasagne, salads and fruit and yogurts. Children with spoke with told us the food was "okay".
- In the 2014 CQC Children and Young People's Survey, the trust scored 47% for the question (asked to parents of children aged 0-7 years): "Did your child like the hospital food provided?" This was worse than other trusts. The trust scored 61% for the question (asked to children and young people aged 8-15 years old): "Did you like the hospital food?" This was consistent with other trusts.
- The outcomes of the survey led to the trust reviewing its catering provision, working with the catering leads to encourage broader menus.

- The paediatric physiotherapists had a new gym which was adjacent to the paediatric wards which meant children and young people had easier access to the gym when needing exercise. The gym was equipped with new exercise equipment which young people found popular to use.
- The service had implemented a number of actions since the Friend and Family survey such as making 'take home' drugs more available to speeding up discharge from the ward, embedding 'My Daily Plan' to improve communication and to encourage sharing of questions, improving the play room by having longer hours and more activities for teenagers in the evening.
- For the CQC children's survey 2015, the service scored 74% for the question relating to staff knowing how to care for the child's individual or special needs this was worse than the England average.
- The service had defined processes and pathways in place in terms of managing the transition of patients between services. These included transitional pathways for cystic fibrosis, Primary Ciliary Dyskinesia (PCD), severe asthma, gastroenterology, diabetes, HIV, oncology and Endocrinology. Effective relationships had been established with adult services and other trusts to ensure effective sharing of information and multidisciplinary working to support the transition process for patients.

## Learning from complaints and concerns

- Complaints management had been devolved down to directorate level to ensure ownership of the complaints processes.
- Over the last year, there were 13 complaints of which two were related to the NNU. Both these complaints had been addressed and closed.
- The remaining 11 complaints were attributed to Squirrel Ward (five), Rabbit Ward (four) and Hedgehog Ward (two). The majority of complaints related to communication issues and clinical care and the service responded to these in a timely manner.
- One father gave permission for their concerns and experience to be shared in order that the staff may benefit from hearing their story. This complaint was presented at the paediatric nurses update programme

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where the complaint was worked through in small groups which highlighted the mistakes that had been made. This enabled nurses to put issues into context and how to avoid the situation happening again.

- The service could demonstrate learning from a complaint. For example, the result of one complaint led to improved communication with primary and tertiary care.
- We spoke with five parents and their children who all knew how to make a complaint and knew about the patient and liaison service (PALS) service. There was literature for children to use if they wanted to make a complaint.

## Are services for children and young people well-led?

Outstanding 

Overall, we rated the service as outstanding for being well-led because:

- The service demonstrated a clear vision and strategy for paediatrics which was led by a strong management team. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- The service regularly took part in national research programmes which resulted in the service developing innovative and new ways of working and improving standards of care for children, leading to being a regional centre for some complex conditions.
- The service was responsive to national audits and could demonstrate improvements through their audit programmes, for example additional risk factors being added to the sepsis care bundle following one risk factor being missed when undertaking a neonatal septic screen. The service was making significant progress in understanding its cohort of patients specifically diabetes, epilepsy and asthma.
- Governance and performance management arrangements were proactively reviewed and reflected

best practice. Governance arrangements were formalised and firmly embedded within the service. Staff felt confident about risks being discussed and actioned.

- The service responded to risks and their risk registers demonstrated that risks were identified, recorded and actioned appropriately and were fed into the wider trust governance systems.
- The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to developing new approaches to care and treatment.
- Staff felt happy with the level of engagement and felt confident they could discuss any concerns with their leaders with ease and that they would be listened to. Senior management created an environment where staff were comfortable in raising concerns and following the duty of candour processes.
- There was a very high level of satisfaction with staff telling us they were proud of the organisation and enjoyed working within their teams. Staff at all levels were actively encouraged to raise concerns.
- Staff told us they felt consulted and part of the development of the strategy, they were engaged and enthusiastic about the new developments within the service.
- There was robust and innovative engagement with patient groups for both children and carers such as family engagement days and regular user groups.
- There was an executive director and a non-executive director with responsibility for children and young people's services who championed the service and provided representation at board level.

## Vision and strategy for this service

- The service had a range of developments to further enhance the provision of care for neonates, children and young people in the future.
- There was a Strategic Plan Document for 2014-19 which included the development of intensive and critical care for neonates to match the demand of an increasing catchment area, to develop the rapid response paediatric service and provide specialist paediatric services in community locations, further develop models of hospital care at home and facilitate the repatriation of complex tertiary patients returning to the service, expand the provision of paediatric surgery including ENT and orthopaedic specialities to meet the

# Services for children and young people

needs of children from an extended catchment area, improve the provision of teenage services facilitate children transitioning to adult care, continue to work with Great Ormond Street hospital including repatriation of specialist work and to further develop the services profile as an excellent state of the art paediatric tertiary neonatal service through involvement in national research and innovation. This was reviewed annually by the board.

- The strategic plan also included the expansion of the provision of paediatric surgery, including ENT and orthopaedics, to improve the provision of teenage services to facilitate children transitioning to adult care and to continue to develop relationships with Great Ormond Street Hospital including the return of children who required specialist care
- The service had a vision to further grow its profile as an excellent state of the art paediatric tertiary neonatal service through involvement in national research and innovation.
- Staff we spoke with were aware of the trust's vision and values and they could tell us what the strategy meant to them, which was to provide the best care for patients and to put patients first.

## **Governance, risk management and quality measurement**

- The directorate had strong governance reporting systems in place to support the NNU and paediatrics. There were monthly departmental meetings for paediatrics and the NNU which were reported to the monthly women and children's board meeting which reports to the trust board.
- There were monthly directorate clinical governance meetings which would feed into divisional board meetings and included discussion and information on complaints and litigation, patient experience, meridian feedback, incident reports, clinical audit programme, mortality and morbidity, training and safety requirement, risks and patient safety.
- There were link roles and dedicated staff to lead on governance and quality assurance and dedicated time to undertake their governance duties.
- The nursing quality and performance meeting met monthly. These meetings were documented and reports

would be fed back to the women and children's board monthly on areas such as harm free care, patient experience, incident reports and the nursing performance dashboard.

- As part of the governance performance management processes, incidents were monitored through the departmental and divisional clinical governance meetings, reported to the clinical operations board monthly and also reported to the clinical outcomes safety and quality committee (a subcommittee of the trust executive board) each month.
- The service investigated its serious incidents and action was taken to prevent reoccurrence. We reviewed two root cause analysis reports which demonstrated clear actions and changes to practice.
- There were also monthly Band 7 meetings where feedback from the divisional meetings were discussed and other items such as performance against their audit plans, staffing levels, equipment, IT issues and re development plans.
- Medical staff told us they attended regular half day clinical governance meetings every month which included progress on the audit programme, risks attributed to the NNU and education and infection control issues.
- We found information from governance meetings was cascaded to staff via emails, meetings and handover safety briefings and if staff missed the briefings feedback would be given to them once they arrived on the ward or department.
- There were patient safety and risk feedback newsletters including incidents and learning.
- There was a risk register available which was under continual review to ensure that the content of the register reflected the actual risks within the department.
- There were 13 risks on the service's risk register which were monitored regularly with three high risks for the NNU relating to medical/nurse staffing and lack of space and 10 risks medium risks.
- Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by its NNAP, National Diabetic Audit and Epilepsy 12 data.

## **Leadership of service**

# Services for children and young people

- The service had a Children's Board which provided a forum to establish best practice, high quality safe services and to influence and take forward the strategic direction for children's services. Its remit was to review the services performance for agreed national and regional standards set for children's services and drive improvements where gaps were identified.
- Membership of the Children's Board included medical and nursing staff from the medical, surgical and paediatric divisions along with an executive lead and two non-executive directors.
- The women's and children's directorate was led by a managing director, a divisional director and a general manager. The paediatric service was led by a clinical director, service development lead and a matron and the NNU had a lead clinician and lead nurse. The service had a non-executive lead for the service that would champion issues and ensure the profile of the services was part of the executive meetings.
- The leadership team was well established and had clearly defined roles and responsibilities which demonstrated good leadership across the service.
- Staff across all disciplines told us the leadership was outstanding and all staff we spoke with told us how good it felt to work for the managers. They felt there was a common purpose, staff were engaged and committed to delivering high quality care.
- The service was one of 12 sites in the UK taking part in the SAFE project run by the RCPCH. This involved a core team from the service attending the programme and returning to implement and trial different models of care.
- The aim of the SAFE project is to reduce the number of preventable deaths within paediatric departments. For example the service had implemented three staff huddles per day, 'my daily plan' which was a whiteboard kept at each patient's bedside for the patient or parent to complete and gave the opportunity for any concerns to be discussed, a PEWS whiteboard and the use of SBAR at the daily handovers..
- Band 7 nurses accessed leadership training via the leadership development programme. There were also courses available via the trust and the East of England Network. The senior team had supported a leadership training programme for all Band 7s which would enable ongoing career progression planning.

- The service had an intense and complex case mix of patients and staff told us the management of the service was excellent.

## **Culture within the service**

- There was a strong culture of teamwork and staff spoke of being proud of their service.
- Staff were motivated and driven to enhance the standard of care that was provided across the service. All staff we spoke with were positive about their work. There was an open and friendly approach and staff told us they worked well as a team.
- A transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- Through 'closing the loop' ward rounds staff felt empowered and part of the decision making processes for caring and treating children.
- Junior medical staff and newly appointed nursing staff told us they came back to work within the service as they were well supported and felt it was an environment that nurtured excellence.
- We were approached by a range of staff across the service wanting to share their work and their specific area of expertise with us. Staff were passionate and proud about their work and wanted to make sure they could showcase their team working and high standards of care they delivered on a daily basis.
- Staff told us they felt valued and well supported as members of the team. Staff felt senior staff were approachable and would often see senior members of staff on the ward and department areas.
- Staff were trained in the Duty of Candour and an outside speaker was used to train senior staff so they could train other staff across the service.

## **Staff engagement**

- Staff told us they felt there was a common purpose, staff were engaged and committed to delivering high quality care.
- There was an annual staff survey, which sought the views of staff perception about working for the organisation.
- Staff were engaged and supported through monthly NNU newsletters, trust wide newsletters, listening

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events/staff huddles/revalidation/uplift of Band 5 staff and improved staff education. For example, in January 2016 the staff newsletter focused on care of the dying patient and the Sepsis 6 care bundle.

## Public engagement

- The service took the Friend and Family Test results seriously with a comprehensive plan to improve in all areas where parents, children and young people identified as needing improvement.
- The service had plans in place from the results of the Friends and Family Test as well as their own inpatient survey undertaken in the summer 2015. Plans included improving communication, waiting times, the environment, staffing and areas of poor practice and patient safety. The plans included what the action would be, who was responsible for the action, when the action would be completed and when an update on progress was required.
- For example communication sheets with clear treatment plans had been designed and were being piloted on a small number of complex patients before being used across the whole paediatric service. Nursing plans now contained an area where parents signed to demonstrate there were aware of what care and treatment was being carried out.
- Work to improve the time waiting for take home medications had been completed as well as improved access to the playroom and new ways of working with the play staff.
- The service also had an open access parent workshop in May 2015 to familiarise parents in the use of open access passports which gave parents information about the use of passports and the opportunity to ask questions and give their views.
- The service held a diabetes family day in 2015 where families could share their experiences of having a child living with diabetes. The feedback from parents was very positive.

- The service had family engagement days which brought families together to share their experiences and meet other families with children being cared for at the hospital.
- The service had a regular user group (RUG) which was a group of young people aged between 12 to 17 years. The aim of the group was to make sure they had a say in how the service was being developed. There was also a parent's user group (PUG) running alongside this group.
- The service also supported families of children with long term conditions to understand/manage their care through educational days for diabetes, endocrinology and epilepsy.
- The service had access to charitable funds. These were used for improving the facilities for parents, neonates, children and young people.

## Innovation, improvement and sustainability

- There was children's assessment knowledge and examination skills (CAKES) course which was accredited by the Royal College of Nursing (RCN) and RCPCH and took place three times a year. This was a multi-professional educational course which ensured competency/confidence of staff in all settings to recognise sick children needing urgent hospital treatment and appropriately assess/manage children safely outside-of-hospital settings and at home. This had been developed by the PAU staff and was open to staff from outside the organisation.
- The service participated in the flying start '5 to thrive' project which was working in partnership with children's centres, primary care and Luton local authority to ensure a cohesive way of working across boundaries to improve parenting from pre- conception through to maternity and paediatrics. Staff from the service attended workshops to enable better outcomes for children and young people.

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Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Luton and Dunstable Hospital provided end of life care throughout the trust. Patients with palliative or end of life care needs were nursed on general wards throughout the hospital. There were 1,187 deaths in hospital at the trust between July 2014 and June 2015. Data provided by the trust indicated that the specialist palliative care team had received 447 referrals during this period.

The trust told us that the specialist palliative care team (SPCT) had received 208 referrals between July and December 2015. 159 (76%) had a diagnosis of cancer and 49 (23%) had a non-cancer diagnosis.

Before our inspection, we reviewed performance information from and about the trust. During our inspection we visited eight wards where palliative or end of life care was provided. We visited the mortuary, the bereavement centre and the specialist palliative care team (SPCT) general office. We spoke with 35 members of staff, which included the SPCT, doctors, nurses, health care assistants, allied health professionals, senior managers, porters, administration staff, the chaplain and bereavement staff, volunteers and mortuary staff.

We reviewed documents relating to the provision of end of life care provided by the trust and the medical and nursing care records of 12 patients receiving end of life care. We observed care and treatment being provided by medical and nursing staff on the wards. We spoke with three patients who were receiving end of life care and four family members.

## Summary of findings

End of life services at Luton and Dunstable University Hospital were rated as good overall.

Patients and relatives all spoke positively about end of life care. Staff provided compassionate care for patients. Services were very responsive to patients' individual needs and those of their families and next of kin.

There were arrangements to minimise risks to patients with measures in place to safeguard adults from abuse, prevent falls, malnutrition and pressure ulcers and, the early identification of a deteriorating patient through the use of an early warning system.

End of life care followed national guidance and the trust participated in national audits. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

The results of the 2013/14 National Care of the Dying Audit of Hospitals (NCDHAH) highlighted a number of areas for improvement. The hospital had since made some progress on the implementation of the action plan.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms we inspected were appropriately completed.

Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and their cultural and spiritual needs. The bereavement support staff provided

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good support to relatives after the death of a patient. The hospital had a rapid discharge service for discharge to a preferred place of care. The trust had not yet completed an audit of patients achieving their preferred place of dying.

There was an improvement plan in place for end of life care that was overseen by a strategy steering group. There had been a number of changes put into place in the previous twelve months. These included a new personalised care framework, to replace the discontinued Liverpool Care Pathway, improved rapid discharge processes and the appointment of an end of life care specialist nurse to roll out the new documentation and provide training.

There was evidence of clear leadership in both the palliative care team and at board level. The trust had a clear vision and strategy for end of life care services and participated in regional and locality groups in relation to strategic planning and implementation.

However we found that:

Not all advance care plans patients had made in the community had been reviewed by the hospital's SPCT to ensure they were valid, current and that care and treatment provided was still meeting patients' expressed wishes.

The trust had not completed an audit of patients achieving their preferred place of dying. This meant, because it was not identified, this information could not be used to improve or develop services.

The trust did not collect information of the percentage of patients that had achieved discharge to their preferred place within 24 hours. Without this information they were unable to monitor if they were meeting patients' wishes and how they could make improvements.

## Are end of life care services safe?

Good



Overall, we rated safe as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Where incidents had occurred investigations had taken place and, where relevant, relatives had received an apology.
- Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers and the early identification of a deteriorating patient through the use of an early warning system.
- We saw good practice including the storage of patient identifiable information, clean clinical areas and good infection prevention and control practice.
- Patient records and do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently.
- Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.
- The SPCT and bereavement support staff had completed all necessary mandatory training required for their roles. Mortuary staff had completed all mandatory training for their roles, including infection prevention and control.
- Medical and nursing staffing was appropriate and there was good emergency cover.

### Incidents

- Staff reported incidents through the trust's electronic reporting system. All staff we spoke with were familiar with this process. Staff told us they were encouraged to report incidents. They gave us examples of reportable incidents such as patient falls, low staffing levels and pressure ulcers.
- There were no serious incidents or never events reported by this core service in 2015. Never events are serious largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).

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- Fourteen incidents were recorded in 2015 that mentioned 'end of life care'. These had been classed as low risk. The mortuary had six incidents reported during this period. Appropriate actions were taken following the incidents to mitigate future risk. A member of staff provided an example of when an incident occurred and how that was dealt with. This related to improving communication between the women and children's unit and the mortuary.

## Duty of Candour

- 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.
- Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and either severe or moderate harm has been caused. Nursing staff we spoke with were aware of the duty to be open and honest with patients and relatives about any care or treatment that may have gone wrong. Staff said they believed they worked in an open culture and would be confident about reporting concerns or possible mistakes that had been made.

## Cleanliness, infection control and hygiene

- The specialist palliative care team were aware of their roles and responsibilities with regard to infection control. They wore clean uniforms and were "bare below elbow" in clinical areas. The staff had access to personal protective equipment (PPE) and we saw they used them appropriately.
- Two patients and three relatives told us they observed staff wearing protective clothing and they washed their hands between seeing patients.
- Porters and mortuary staff we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access the necessary equipment. The mortuary was visibly clean, well-organised and uncluttered with systems in place for managing human tissue and fluids safely.

- The trust had a care after death policy, which gave guidance regarding specific infections and how potentially infected bodies should be managed after death to minimise infection risk.
- As part of the last offices procedure (the process where the body is prepared for transfer to the mortuary) nursing staff completed a mortuary admission form. This form included information about actual or potential infections and ensured the porters and mortuary staff were made aware of any infection risks.
- Ward staff we spoke with were aware of the procedures to be taken when performing last offices in order to minimise infection risks
- There were arrangements for separate storage and isolation of decomposed remains in the mortuary.

## Environment and equipment

- Equipment was available to meet patient needs such as syringe drivers and pressure relieving equipment.
- The National Patient Safety Agency (NPSA) recommended in 2011 that their preferred syringe drivers should be withdrawn as soon as locally feasible, but before 31 December 2015. The trust had replaced the syringe drivers with a recommended alternative following a comprehensive education programme for all nursing staff. The trust told us only one type of syringe pump was used at the hospital. This ensured continuity of care. Syringe drivers we saw in use had been set up correctly and were used appropriately.
- The trust provided evidence of a robust maintenance schedule and asset list of syringe drivers including next service dates.
- The mortuary was equipped to store 79 deceased patients. Staff told us these facilities were sufficient to meet the needs of the hospital and local population.
- We looked at records relating to cleaning rotas and equipment checks and saw these were updated regularly.
- The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.
- The trust did not have any specific fridges for bariatric or paediatric patients, however mortuary staff confirmed that the current fridges were able to accommodate

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bariatric patients. We were told that the trust were in the process of purchasing equipment, but were unaware of the delivery date of this equipment at the time of the inspection.

## Medicines

- The National Care of the Dying Audit 2014 showed the trust achieved the England average for their clinical protocols relating to the prescribing of medication for the five key symptoms (pain, excessive respiratory secretions, breathlessness, nausea and vomiting and agitation) at the end of life.
- We reviewed the medication records and medical and nursing case notes of eight patients identified as being in the last hours or days of life. We saw that anticipatory medications, which are medications prescribed for the key symptoms in the dying phase, for pain, agitation, excessive respiratory secretions, nausea and vomiting were prescribed appropriately.
- One nurse within the specialist palliative care team was a nurse prescriber and two nurses were working towards obtaining this qualification.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that they may need to make them more comfortable). The guidance they provided was in line with trust guidance.
- We were told by staff on the wards we visited that medication for end of life care was available on the ward and was easily accessible. There were locks on all store rooms, cupboards and fridges containing medicines and intravenous fluids on the wards we visited. Keys were held by nursing staff.
- Medicines were stored at suitable temperatures to maintain their quality. The temperature of medicine fridges were monitored daily. We saw all areas complied with this as daily temperatures were recorded. The room temperatures were also monitored and were within appropriate range.

## Records

- In all ward areas we inspected, we saw records were stored securely and could only be accessed by people who had the appropriate authority.
- The trust had introduced a new end of life care plan called 'Principles of Care for a Patient who is Dying' in 2014. An audit of 40 sets of notes allowed a benchmark to be set and ensure that staff had all the information

they required to deliver the care required to meet each patient's needs. We reviewed the medical and nursing notes for 12 patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.

- In medical notes for patients approaching the end of their lives, we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment whilst still supporting the patient and their families.
- We were shown the record keeping system in the hospital mortuary. The system ensured that details of patients who had died and of their property were accurately recorded and promptly made available to the County Coroner's Officer if required. Records were kept secure in a locked filing cabinet.
- We reviewed 28 do not attempt cardio-pulmonary resuscitation (DNACPR) records and found these were consistently well completed in accordance with trust policy.

## Safeguarding

- Safeguarding training was mandatory. Staff from the specialist palliative care team had all undertaken safeguarding training. They were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children. Completion of safeguarding adults training and children level 2 training was 100%.
- The trust had a safeguarding lead. Staff were aware of how to contact the lead and told us they could approach them for advice if they needed to.
- We saw a safeguarding board displayed on the wards visited which provided information and contact details to patients, relatives and staff.

## Mandatory training

- We examined the training records for the nursing staff and consultants in palliative care and found that all had received up to date training in mandatory subjects including infection control and advanced life support as well as statutory training including health and safety, fire safety and moving and handling.
- Syringe driver training was included in the mandatory training programme for all registered nurses who worked in a clinical area. Records showed that 75% of nursing staff had received this training at the time of our inspection.

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- Mortuary staff had completed all required mandatory training, which included infection prevention and control.

## Assessing and responding to patient risk

- We reviewed the notes of 12 patients. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing skin pressure damage was assessed using the Waterlow Scale.
- Risk assessments for patients were completed appropriately and reviewed at the required frequency to minimise risk. For example, patients who were at risk of pressure damaged were nursed on pressure relieving mattresses.
- Staff told us that patients requiring end of life care were identified at ward rounds. Once identified, the ward team would refer the patient for specialist care. Not all patients identified as requiring end of life care were referred to SPCT team. The SPC team operational policy provided guidance on the referral criteria. For example it stated referrals were to be made to the SPCT for patients with pain related to progressive disease uncontrolled by simple analgesia or complex symptoms requiring further assessment on discharge/ specialist support at home.
- If a patient admitted through the emergency department had previously been identified as palliative and seen by the SPC team, an alert would be flagged on the Patient Information System (IPS) would directly alert the SPVT within the hospital. If the patient was admitted as a direct GP referral the in house district nurse liaison team would directly contact the SPC team
- The SPC team had a triage and prioritising system for their referrals. Staff made referrals via email, phone call or directly to the team when they visited the wards or attended ward rounds.
- The trust advised that 100% of patients referred to the palliative care team were seen within 24 hours between July and December 2015.
- Ward staff and medical staff told us the palliative care consultant was always available during office hours for medical advice. We noted that there was a 7 day a week telephone advice line provided by the local hospice.
- The trust used the National Early Warning Score (NEWS) system for monitoring acutely ill patients. This system

alerted staff of patients 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 SPC team.

- DNACPR records had been signed and dated by appropriate senior medical staff and there was a clearly documented reason for the decision recorded on the form, with clinical information included. Discussions with families were documented in the medical notes.
- Staff used an early warning system to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores were used to monitor patients. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes recorded clearly.

## Nursing staffing

- The specialist palliative care team consisted of a lead nurse, and three whole time equivalent (WTE) palliative care clinical nurse specialists (CNS). There was also one WTE end of life care nurse. There were no staff vacancies in the team.
- We found staffing levels on the wards we visited were sufficient to ensure that palliative care patients received safe care and treatment.
- The palliative care clinical nurse specialists were available Monday to Friday from 8am to 4pm. Out of hours advice and support was available from a local hospice through the advice line.
- The team lead manager told us their staffing model was adequate to provide a five day service taking into account annual leave and sickness.
- We were told that shifts rarely needed to be filled with bank and agency staff. If agency staff were required they would follow the trust's policy and ensure an induction checklist was completed for the staff member.
- Each ward had an identified end of life care link nurse. This helped to ensure that patients who were at the end of their life had early and on-going access to appropriate care and treatment. End of life link nurses had received additional training, which helped them identify patients who required end of life interventions. They acted as a first point of contact for advice to other nursing staff on their wards.

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## Medical staffing

- Medical staffing met that recommended in the (NICE) guidelines. Commissioning Guidance for Palliative Care published collaboratively with the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK recommends 1.0 WTE consultant per 850 acute beds.
- The trust had one WTE palliative care consultant who worked 9am to 5pm Monday to Friday. Outside of these hours, there was a consultant on call rota with the neighbouring hospice.
- Annual leave or sick leave cover was provided by a locum palliative care consultant. We spoke with a locum consultant who confirmed that they had an induction before taking up the post to cover leave.
- The consultant took referrals from the SPC team based on the complexity of their needs and also worked in an advisory capacity with consultants in other specialities.

## Major incident awareness and training

- There were documented major incident plans on the wards and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT staff were aware of the trust's major incidents policy?
- There was an escalation plan in place for the mortuary in case of a major emergency. This was reviewed annually. Additional external storage facilities had been identified and agreed.

## Are end of life care services effective?

Good 

Overall, we rated effective as good because:

- An effective replacement for the Liverpool Care Pathway, end of life care planning documentation was in place.
- The trust participated in national and local audits, for example, the National Care of the Dying Audit (2014).
- Policies and procedures were accessible, and based on national guidance.

- Care was delivered and monitored to meet patients' needs and to demonstrate compliance with national standards. Outcomes were measured and used to improve the service.
- Patient's pain, nutrition and hydration was appropriately managed.
- There was a multi-disciplinary approach to care and treatment.
- Staff were appropriately qualified, competent and supported, via effective supervision and appraisal systems, to carry out their role.
- The service provided weekday cover with weekend cover provided by palliative care nurse specialists based at the local hospice.
- Where patients were identified by staff as lacking the mental capacity to be involved in DNACPR decisions, family members were consulted and decisions taken in patients' best interests.

However, we found that:

- Not all advance care plans patients had made in the community had been reviewed by the hospital's SPCT to ensure they were valid, current and that care and treatment provided was still meeting patients' expressed wishes.

## Evidence-based care and treatment

- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to recognise, communicate, involve, support, plan and do, the SPC team had developed a personalised care plan for each patient in the last days of life with guidance for staff of how to best meet the five priorities of care.
- We saw from training records that staff had received training during 2014/15 in the use of the new care plan, called principles of care for a patient who is dying. Ward champions and the end of life care nurse continued to deliver training sessions on the implementation and delivery of training about the care plan.
- The SPC team had undertaken an audit in October 2015 monitoring its use of the new care planning documentation, Actions taken by the team as a result of the audit included the continuation of education on the wards to doctors and nurses and to review the care plan documentation again by January 2016, which had been actioned.

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- The trust did not participate in any national accreditation schemes such as the Gold Standard Framework (GSF). The GSF provides training in relation to end of life care and an accreditation scheme for trusts that consistently meet national guidance. The team told us there were no plans to introduce the GSF at the trust.
- The trust had been selected by the NHS National Institute for Health Research (NIHR) as one of ten trusts to introduce the AMBER care bundle at the hospital. The AMBER care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that a patient may have a few months left to live. We saw that the team were in the process of submitting their application to the NIHR.
- End of life care services followed guidance by the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. Standards were being met with the provision of a specialist palliative care team who provided weekday working and could be contacted in person or by telephone during all out of hours.
- The trust had a policy for advance care planning. Advance care planning is a process of discussion between an individual and their care provider. It might include the person's concerns, what is important to them, their understanding of their illness, their preferences for types of treatment or where they wish to be cared for. However, we found that these conversations with patients were generally undertaken by the community palliative care team, rather than the hospital SPC team.

## Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy.
- Syringe drivers and appropriate use of pain relief medicines met patient's assessed needs. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin
- We saw good evidence of appropriate prescribing, administration and documentation of medication including anticipatory medicines which met national guidance NICE Clinical Guidance 140 'use of opioids in palliative care'
- The SPC team did not undertake any audits to monitor on how well they complied with the management of pain relief, or with Nice Guidance on the 'use of opioids in palliative care.'

- We saw evidence that pain relief was being given and monitored, for example, site intensity and type of pain. The wards that we visited used the pain thermometer and a pain intensity rating scale. These had been completed appropriately and showed that patients had been asked about their levels of pain. One patient we spoke with confirmed they had been asked to describe their pain and felt they had been listened to.

## Nutrition and hydration

- Nutrition and hydration risks were assessed and monitored on patients' records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in as much of the patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- The trusts policy for nutrition in end of life care states that if patients are able to eat and drink this should be encouraged unless they choose not to.
- We viewed guidance on the use of mouth care in the last days of life that included action to be taken in the event of a patient having a dry mouth, coated tongue or pain/ulceration.
- The National Care of the Dying Audit 2014 results for nutrition and hydration showed that the trust received a score of 50 against a national average of 41 for nutritional requirements and hydration requirements scored 66 against a national average of 50. This meant that the trust performed better for nutrition and hydration than the national average.

## Patient outcomes

- The trust had participated in the National Care of the Dying Audit (NCDA) 2014 and had achieved two of the seven organisational key performance indicators. Out of the indicators that the service did not achieve, two of these indicators were worse than the England average. These were 'formal feedback processes regarding bereaved relatives/friends views of care delivery' and 'access to information relating to death and dying'.
- The trust also performed below the England average eight out of ten of the clinical key performance

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indicators. The worst performing indicator was 'a review of the number of assessments undertaken in the patient's last 24 hours of life', scored 37 compared to an England average of 82.

- The trust had an action plan to enable them to track the actions required to meet all of the key performance indicators of the audit. The trust had addressed a number of issues following the audit, including the development of bereavement care, ensuring training in end of life care was mandatory for staff caring for dying patients and the development of the last days of life care plan.
- The action plan was being monitored through the End of Life Steering Group who met monthly.
- The trust had submitted information for the NCDAs for 2015. The SPCT were waiting for the results, which were due early in 2016.
- The service contributed data about end of life care to the National Minimum Data Set. The National Minimum Data Set (MDS) for Specialist Palliative Care Services is collected by National Council for Palliative Care on a yearly basis. The aim of this was to provide an accurate picture of hospice and specialist palliative care service activity. Information collected included numbers of patients using the services, mean length of stay / care, demographic information: sex, age and ethnicity, a breakdown of diagnosis, particularly in the case of conditions other than cancer and contacts between staff and patients / carers.
- The SPCT had started to collect information about the outcomes of patients' care and treatment. They monitored the level of intervention provided, for example, whether the intervention was a professional to professional advice meeting, a one off meeting with the patients to provide advice or longer term intervention to provide support to the professional and patient from diagnosis until death.

## Competent staff

- Nurses on medical wards told us that they felt competent to provide end of life care for patients and were aware they could refer to the SPCT. During our inspection, a patient was identified as requiring palliative care. The patient was referred to the palliative care team and we saw they attended the ward promptly and spent time with the medical and nursing team to discuss care options.

- A successful Macmillan business case had resulted in the recruitment of an end of life care nurse who was ward based. The nurse's specific remit was to support and educate staff to ensure the best care for patients and their relatives.
- We spoke with medical staff, including locum consultants, and all were aware of the palliative care team and knew how to seek advice and support.
- We saw evidence that registered nurses from each ward had received training to enable them to safely administer medications through infusion pumps.
- We saw that the SPCT had received monthly clinical supervision. Staff told us they had received an annual appraisal and records confirmed that 100% of staff had had an appraisal.
- The SPC team supported and delivered the education programme at the trust. During 2014/15, 75% of trained nurses within the medical, elderly care and critical care wards received end of life care training. End of life care training was also provided to preceptorship nurses and sessions were also delivered as part of the nurse induction programme.

## Multidisciplinary working

- Members of the specialist palliative care team participated in multidisciplinary team meetings, working with other specialists to support good quality end of life care across clinical specialties.
- The SPCT told us they met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting attended by other professionals, including an occupational therapist and the chaplain.
- The SPCT had forged strong bonds with community nursing teams, the hospice and other local hospitals. This helped when arranging fast track discharges to the patients preferred place of death.
- There were entries by all members of the multidisciplinary team in the patients' medical records that we reviewed.
- We observed a multidisciplinary team meeting during our inspection. The SPCT multidisciplinary team (MDT) was a multi-professional group comprised of staff from the trust and community team, integrating palliative care across primary and secondary healthcare settings including care homes. The MDT took place weekly. The aim of the MDT was to ensure a coordinated approach

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to providing active and holistic care/assessment to patients with any advanced, progressive illness with the aim of achieving the best quality of life for patients and their families.

## Seven-day services

- The service was provided from 8am to 4pm, Monday to Friday. Staff were based within the Macmillan Cancer Unit at the hospital.
- Out of hours advice and support was available from the local hospice through the 24-hour advice line. If appropriate face to face assessments were provided, hospice staff had honorary contracts with the trust and were available to come into the hospital at weekends to assess and support patients, families, medical staff and ward staff if required.
- Every Friday, the trust shared information with the hospice about the patients currently within the hospital who needed review over the weekend. An electronic handover form was completed for each patient and emailed to the hospice. On Monday morning, written feedback was provided to SPCT from the hospice team regarding updates of patient assessment over the weekend.
- Physiotherapy and occupational therapy provided a weekday service at the hospital. On Saturdays, there were occupational therapists and physiotherapists available that provided treatment for urgent patients in the trust.
- Mortuary staff were on call out of hours for urgent cases, such as tissue donation.
- Bereavement services were open Monday to Friday 9:30am to 3:30pm.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including weekend and out-of-hours cover via an on-call system.

## Access to information

- Staff had access to electronic information, such as policies, national guidance, newsletters and minutes of meetings.
- The SPCT nurses visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients.

- Initial feedback from ward staff has been that the recently introduced end of life care plan was a much better tool for recording information and for providing continuing care to patients. Ward nurses we spoke with also confirmed this.
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- If patients required support, staff could access palliative support through the out of hours service or review the information available on the intranet for guidance.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 12 medical and nursing records of patients. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and where appropriate, their mental capacity was assessed and recorded.
- We saw clear information about the Mental Capacity Act 2005 (MCA) guidance on the trust's intranet.
- Staff told us they received training on consent and Mental Capacity Act (MCA). When patients did not have capacity to consent to care and treatment, staff were aware of what actions to take. Training records seen evidenced that all the SPCT had received training on the MCA.
- During our visits to the wards, we saw and heard several occasions when staff sought the consent of patients before an intervention.
- We found staff were knowledgeable about Deprivation of Liberty Safeguards (DoLS) and where appropriate, DoLS assessments were completed with a multidisciplinary approach and families were involved in accordance with trust policy?
- We reviewed 28 DNACPR records and found these were consistently well completed in line with trust policy. Staff ensured they documented whether the patient had capacity to be involved in the decision making and discussions with families were documented. DNACPR records had been signed and dated by appropriate senior medical staff. Discussions with families were documented in the medical notes.
- We examined the results from a DNACPR audit carried out in October 2015. The hospital's resuscitation team

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told us that they carried out an audit of 108 DNACPR forms on medical and surgical wards and they fed back the results to the specialty lead. The audit identified that 67% of the forms required amendment. For example, they found that 63% of the forms audited did not contain evidence of a discussion with the patient or family.

- The resuscitation team had developed an action plan from the documentation audit results. The action plan identified commonly missed information and the specialty with most missed information. The resuscitation team fed back the audit information to each specialty and carried out targeted training sessions when necessary.

## Are end of life care services caring?

Good



Overall, we rated the service as good for caring because:

- End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients.
- Patients were supported, treated with dignity and respect, and were involved in their care. All the patients and relatives we talked with spoke positively about the care they had received.
- Information on end of life and what to expect was available for patients and relatives throughout the hospital, through the specialist palliative care team and through the bereavement and chaplaincy teams.
- Emotional support through counselling services were available to both patients and their relatives.

### Compassionate care

- We spoke with three patients and four relatives and all said the care they had received, or observed, had been compassionate. The patients told us they were treated with dignity and respect by all the staff on the wards.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- One patient explained how the news of their diagnosis had been explained to them. They said the consultant

had been sensitive but also very clear and direct, which they said they really appreciated. The consultant had also arranged for a nurse to be present to provide additional support.

- The National Care of the Dying Audit 2013/14 (NCDA) showed that the trust had not achieved the organisation KPI of a clinical protocol promoting patient privacy, dignity and respect, up to and including after the death of a patient. We saw that the trust had produced an improvement plan which the SPC team monitored and reviewed on a monthly basis and presented to the trust board quarterly. This improvement plan was developed to address the shortfalls and issues raised by the NCDA. We reviewed the most recent improvement plan dated January 2016 which confirmed that the target date of December 2015 had been met.
- The patient experience results (February 2015) released by Macmillan Cancer Support, based on research commissioned by NHS England showed the hospital was among the top ten for patient experience across England.
- We observed that staff handled bodies in a professional and respectful way. The mortuary staff and porters told us that they did not have any concerns about the way ward staff cared for patients shortly after death.
- The mortuary staff explained how they managed and arranged visits for relatives who wished to view the deceased. They ensured that people could take the time they need and did not rush people so that they can say goodbye to their relatives and ask any questions they may have of the bereavement team.
- Visits were generally co-ordinated with the bereavement service and the mortuary staff made sure they were well prepared for any viewings.

### Understanding and involvement of patients and those close to them

- We spoke with three patients and four relatives about the care they were receiving and information that they were provided. People were highly complementary about the information that they had been provided with by the staff and felt that “staff could not do enough for them.”
- We reviewed 12 patient records across the wards. We saw that patients referred to the SPC team were kept actively involved in their own care and relatives were

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kept involved in the management of the patient with patient consent. We saw documented discussions with patients and their families regarding care and treatment.

- The ward manager on ward 16 told us that they included families in caring for their relative, but only as much as they wanted to be involved. Areas where family members supported their relatives included mouth care, which we observed whilst visiting this ward. Family members also supported relatives at meal times.
- The bereavement office stated that they would organise for medical staff to be available when relatives come to collect the death certificate to answer questions relating to the death, if this is what family members wanted.

## Emotional support

- Ward, nursing and medical teams offered emotional support in addition to the palliative care team. The trust also had a chaplaincy service and a clinical psychologist, if required. The clinical psychologist provided support to people with a life-limiting illness, as well as providing specialist support to family members affected by a person's illness
- Support for carers, family and friends were also provided by the chaplaincy and bereavement services.
- Where relatives were present at the time of death, the ward staff explained that the bereavement service would contact them the next working day. The bereavement Support Officers were available from Monday to Friday from 9am to 4pm with a telephone message service outside of these hours.
- The bereavement service 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.
- On one of the wards we visited, we saw a family being offered emotional support and privacy to discuss the ongoing care for their relative who was being cared for using the end of life pathway.
- The chaplaincy service provided a 24 hour service with a full time lead Chaplain, supported by bank chaplains from other religions or faiths.
- Friends and family of the deceased were offered a bereavement appointment for emotional support.
- The chaplaincy services within the trust provided support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith.

- The patients and visiting family members we spoke with told us they felt emotionally supported by all the staff involved in their care. A family member told us they enjoyed speaking with a chaplaincy volunteer who visited the ward daily. They described their conversations as "comforting."

## Are end of life care services responsive?

Good



Overall, we rated responsive as good because:

- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The service had responded to the requirements of changing national guidance and expectations by implementing changes and improvements to the end of life care pathway in the hospital.
- The SPCT responded quickly to referrals that were made and ward staff were positive about the support, advice and input provided.
- The trust could organise rapid discharges effectively.
- Various information leaflets were available from the palliative care team, the bereavement service and the chaplaincy service.

However we also found:

- The trust had not completed an audit to check if patients achieved their preferred place of dying, although this information was recorded for each patient discussed at MDT meetings. The MDT identified the patient's preferred place of care, actual place of death and the reason for any variance. This meant the information could not be used to improve or develop services as it was not collected as a whole.
- The trust did not collect information of the percentage of patients that had achieved discharge to their preferred place within 24 hours. Without this information they were unable to monitor if they were meeting patients' wishes and how they could make improvements. However, this information was collected by the community team and shared with the trust palliative care team. Access for the trust palliative care CNS team to view PPD (preferred place of death) on the community system had been provided following our inspection.

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

- All the nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. A visitor told us they had been offered a side room for their relative but had declined.
- Nursing staff told us that where patients were nursed in a side room, relatives were able to stay in the room with them and wards had access to appropriate facilities for relatives, for example, comfortable chairs and hot drinks.
- 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 un-limited time with the patient.
- The trust supported patients to achieve their preferred place of death either through rapid discharge to home, hospice or nursing home, or by ensuring high quality care for patients who wished to die at the hospital.
- The trust did not directly collect information of the percentage of patients who achieved dying in their preferred location. However, we saw that this information was collected by the SPC community teams covering Luton, Bedfordshire and Hertfordshire. We observed that the information was provided to the hospital team at the specialist palliative care MDT, which met weekly.

## Meeting people's individual needs

- End of life patient information packs had been introduced and were given to all patients and families.
- Translation services were available 24 hours per day through a telephone service. Staff told us there were generally no delays in accessing this service when needed.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they cared for. They were able to explain procedures for caring for patients with different religions and how they adapted the care accordingly.

- Relatives said they were accommodated as best as the staff could manage, with flexible visiting times and ensuring comfortable chairs were available if family members stopped with the patient overnight.
- Patients were discharged with their syringe drivers in place to avoid any gaps in delivery of medicine and pain relief.
- A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following bereavement.
- Patients' individual wishes were recorded in the personalised care framework documents. This could record their preferred place of dying and any wishes they had for their spiritual needs.
- There was a multi-faith chapel available at all times of the day and night that held information relevant to people from different faiths and religions.
- Mortuary viewing facilities were appropriate and allowed relatives privacy. The room was appropriately decorated and staff were available to answer questions and signpost relatives to appropriate people if they had any questions or queries.

## Access and flow

- There was a telephone referral system for the SPCT, where information was taken by the administrative staff ready to be reviewed normally the following day by the team. However, informal triaging took place throughout the day and any urgent referrals, for example where a patient was in pain, were prioritised.
- Following our inspection, the trust forwarded us evidence of an audit of urgent telephone referrals to the SPCT for November 2015. The audit identified that the team had received 22 urgent referrals during this month and that 21 patients were first seen on the day of referral. One patient, who had been admitted over the weekend, was seen within 48 hours. This demonstrated that SPCT response times were responsive and no patient had waited more than two days for a first clinical assessment. The SPCT were visible on the wards. Nursing staff knew how to contact them. Referrals were made by telephone contact. Ward staff told us there were no delays for patients to be seen.
- The National Care of the Dying Audit 2014/15 identified that access to specialist care in the last hours of life was similar to the England average.

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- There was a rapid discharge process in place which usually took place on the same day. Patients were referred to the discharge team by the ward staff following a discussion by the medical staff with the patient and family about their medical care and expected prognosis. The team met with the patient and if appropriate with family or friends to discuss the individual wishes on discharge and how these could be met, and to give the opportunity for any questions regarding their ongoing care.
- We met with two members of the discharge planning team. They had contact with hospital wards every day, including weekends. The team completed the necessary paperwork and arranged transport, medication and funding if required. We viewed the documentation for one patient who was waiting to be discharged to a local hospice. We saw that appropriate NHS continuing care funding had been arranged, but that the patient was waiting for a place to become available at the hospice. The records demonstrated that discussion had taken place with the patient, the SPCT and the discharge planning team.
- The SPCT's goal for rapid discharge was 24 hours but could take up to seven days to complete where there were delays caused by a lack of local authority and community resources. Staff from the SPCT told us that they had close working relationships with community teams across Bedfordshire and Hertfordshire. We did not see any evidence around delayed discharges beyond seven days for end of life care.
- A follow up phone call to the patient or family was made within 24 hours post discharge to ensure that care has been provided as planned and that no immediate changes were required by the team.
- We attended a multi-disciplinary team meeting (MDT) where we noted that for each patient discussed at the meeting there was good recording of their preferred place of care, actual place of death and the reason for any variance. The discharge team also attended these meetings. If required they could then start a rapid discharge process.
- The trust was not routinely undertaking patients' preferred place of care/death audits. Without this information they were unable to monitor if they were meeting patients' wishes and how they could make improvements.
- Following our inspection the trust forwarded an audit to assess the frequency of patients' preferred place of

death being met in May and June 2015. The audit demonstrated that of the 59 patients audited 66% achieved their preferred place of death (PPD). The trust identified that the majority of unmet PPDs was as a result of not knowing the patient's preference. This was due to either unexpected deterioration of the patient's condition or not having access to the Advanced Care Plan completed in the community setting resulting in the PPD being unknown to the trust. The trust has confirmed that they now have access to the community services computer system and are developing an action plan to ensure patients' wishes are known and respected.

## Learning from complaints and concerns

- The trust had complaints' policy and procedure and staff knew how to support patients who wished to make a complaint.
- Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- There were very few complaints received in respect of end of life care. There had been five formal complaints made in relation to end of life care in the previous twelve months. Three of the complaints related to the mortuary service and two related to the bereavement service. We saw from information provided by the trust that all complaints had been investigated and appropriate action taken within trust timescales.
- The mortuary manager provided an example of a complaint which had been investigated and the learning from this resulted in a change to practice. Staff had met with the family involved and apologised.

## Are end of life care services well-led?

Good



Overall, well-led has been rated as good because:

- The specialist palliative care team had a clear vision in place to deliver good quality services and care to patients. There was a long term strategy in place with clear objectives.
- We saw strong leadership, commitment and support from the senior team within the cancer services team.

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- The trust had a director and a non-executive director who provided representation of end-of-life care at board level, which is a recommendation of the National Care of the Dying Audit of Hospitals.
- Across end of life services the culture and morale of staff was good. Staff were positive about their experience of working at the trust and were committed to delivering good and compassionate end of life care.
- All staff spoken with during the inspection acknowledged the importance of high quality end of life care.
- All aspects of the bereavement service were well run and the service was focused on the experiences of both the patient and the relatives of the bereaved.
- Staff were committed and motivated to provide an improving service.
- The palliative care service was part of cancer services and was accountable to the surgery directorate of the trust.
- We viewed minutes from the end of life care forum that was attended by nursing, medical and allied health professionals. From this, a quarterly report on end of life care within the trust was produced for the quality and safety committee.
- The strategy group met monthly and reported back to the board on the progress of the end of life improvement plan 2015 to 2016. We viewed the most recent audit of the improvement action plan which had been undertaken in January 2016. This had been fed back to the board through the clinical governance committee.
- The audit plan 2016 showed that audit of end of life care issues were planned for the service showed pro-active rather than reactive leadership of the service.
- The trust had developed a care-planning tool to replace the Liverpool Care Pathway called the Principles of Care for a Patient who is Dying care plan, which we saw, was in use across the trust.
- There was no specific risk register relating to end of life care at the trust. We were told that any risks relating to end of life care, which included mortuary and bereavement services, would be included in the divisional risk registers. We did not find any risks recorded at divisional or trust level. We were therefore not assured that staff were aware of how to identify risks and ensure controls were in place and reviewed, to reduce the impact of risk. This meant that risks may not be appropriately recorded, for example, the risk of not providing a seven-day service at the trust, or the lack for bariatric storage units in the mortuary.
- The trust was not routinely undertaking patients' preferred place of care/death audits. Without this information they were unable to monitor if they were meeting patients' wishes and how they could make improvements.

However, we also found that:

- The service did not have a defined risk register. Risks were collected on the overarching surgery divisional risk register.
- The service was not conducting rapid discharge and preferred place of deaths audits.

## Vision and strategy for this service

- We saw the trust's values on display within the wards which included 'The Luton and Dunstable hospital is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available and with kindness and understanding from all our staff'.
- The chief nurse was the executive lead for end of life care and also chaired the end of life steering group. We saw minutes of meetings they attended where end of life care was discussed both at board level and with specialist staff at the end of life steering groups.
- The trust's strategic objectives for end of life care included: increasing public awareness of end of life care, ensuring dignity and respect, minimising suffering and focusing on patients' needs and preferences.
- We viewed evidence of strategic priorities being discussed at end of life care meetings and we saw that they were incorporated into the trust's action plans in relation to developing end of life care services.

## Governance, risk management and quality measurement

### Leadership of service

- Staff within the palliative care team were very positive about their leadership and the support and encouragement the senior managers and consultants provided. Staff said they felt able to approach managers for advice and there was an open culture where issues and concerns could be discussed.

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- The team monitored its performance through their annual report and work programme. We saw a copy of the 2014-2015 programmes.
- The SPCT took responsibility and ownership of their service. They shared best practice and supported trust staff caring for dying patients. They had a good understanding of how well their service was performing and knew what they wanted to do to improve the service further. The service was represented at board level by the chief nurse.

## Culture within the service

- The SPCT felt there was a good team ethic within the team and they felt well supported by colleagues within the team.
- All staff spoken with during the inspection acknowledged the importance of high quality end of life care. All staff spoke positively about the SPCT.
- Two nurses who had started work at the trust within the last six months said the support from all the staff on the SPCT and on the wards had been excellent. They confirmed that they were also well supported by the chief nurse through this period.
- Nursing staff said the chief nurse and chief executive of the trust had a visible presence in the hospital and would often come onto the wards and speak with staff and patients. Staff said they felt valued as members of their immediate team and the wider trust.
- The mortuary and bereavement staff demonstrated a strong team ethic describing the trust as a good place to work.

## Public engagement

- The bereavement service had undertaken a patient experience survey in June 2014 and we saw the results and report from this work. The feedback was positive with comments about the ease of the process.

- The integrated discharge team had surveyed 211 patients/relatives/carers for the period January to November 2015. The survey showed a high level of satisfaction with the service.
- The SPCT organised a public engagement event within the hospital in October 2015 which was attended by approximately 150 members of the public. The aim of the event was to raise awareness about end of life care to patients and those close to them.

## Staff engagement

- An extensive staff awareness campaign was undertaken by the team before it rolled out the new end of life care planning documentation across the trust.
- Information was provided to the staff through a regular trust newsletter and also from email updates from the chief executive.

## Innovation, improvement and sustainability

- Service improvements under the commissioning for quality and innovation framework (CQUINN) 2014/15 included 75% of nursing staff in medicine, elderly care and critical care receiving end of life care training, which was achieved. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients.
- A successful Macmillan business case had resulted in the recruitment of an end of life care nurse who was ward based. The nurse's specific remit was to support and educate staff to ensure the best care for patients and their relatives.
- End of life care resource folders were available on each ward and contained a wide range of useful information for ward staff to give to patients and their families.
- A credit card sized information checklist had been given to each staff member in the hospital. The card was called 'A must do for the dying patient' and was a checklist for staff on actions they should take when a patient was identified as requiring palliative care. The SPCT contact details were also listed on the card.

# Outpatients and diagnostic imaging

Safe	Good	
Effective		
Caring	Good	
Responsive	Outstanding	
Well-led	Outstanding	
<b>Overall</b>	<b>Outstanding</b>	

## Information about the service

Luton and Dunstable University Hospital NHS Foundation Trust provides out-patient services to the population of Luton, South Bedfordshire and parts of Hertfordshire and Buckinghamshire. Out-patient service provision includes; orthopaedics, trauma care, ear, nose and throat (ENT), dermatology, gynaecology and ophthalmology. The trust is the regional service centre for bariatric patients and the second largest breast screening provider in England.

Outpatient clinics are held across the main hospital site with off-site facilities including the orthopaedic, breast screening centre and fertility clinic; all located a short distance from the main site. Physiotherapy and occupational therapy services have additional clinics across Luton and Dunstable. Outpatient appointments are available from 8.30am-5.30pm, Monday to Friday, with additional evening and Saturday clinics established.

Diagnostic services include: diagnostic imaging and diagnostic laboratories such as pathology, biochemistry and microbiology.

The diagnostic imaging department was open for appointments from 8am to 9pm and offered plain film radiography, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound, fluoroscopy and breast imaging. The majority of services operated a seven day service with additional support for diagnostics out of hours. Diagnostic laboratories offered a 24/7 service.

The service is managed by the Diagnostic, Therapeutic and Outpatients division. The division has a nominated

divisional director and pathology director and divisional general manager. They are supported by lead clinicians and managers in all areas of the service including blood sciences, outpatients, dietetics and imaging.

During January to December 2015, the hospital facilitated 387,596 outpatient appointments, of which 29% were new appointments and 53% were follow up appointments (9% of appointments were not attended by patients).

We carried out an announced inspection on 19 January 2016 and an unannounced inspection on the 4 February 2016. We inspected a number of the outpatient clinics and diagnostic services within the main site including:

- Bariatric Services and Obesity Clinic
- Biochemistry laboratory
- Cardiology clinic
- Care of the Elderly clinic
- CT scanning
- Diabetic and Endocrine clinic
- Ear Nose and Throat (ENT)
- Haematology laboratory
- Head and Neck clinic
- Maxilla-Facial clinic
- Microbiology laboratory
- MRI department
- Nuclear Medicine department
- Ophthalmology clinic
- Pathology laboratory
- Rheumatology clinic
- St Mary's clinic
- Urology One Stop
- X-ray department

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In addition we also inspected the Breast screening and Orthopaedic Hub which was situated a short distance off site.

We spoke with 44 patients and relatives and 83 staff including nursing, medical, allied health professionals and support staff. We also reviewed the trust's performance data.

## Summary of findings

Overall, we rated the service as good for safety and caring and outstanding for responsiveness and well-led. Effective was inspected but not rated.

Diagnostic services had established a seven day working programme with flexibility of services to provide timely diagnostic procedures for patients. Appointments for both diagnostic services and clinic appointments were flexed according to demands of the service and to meet the individual needs of the patients.

The division were working towards increasing outpatient clinics to include evenings and weekends on a routine basis and offered flexibility according to patient condition and any demands on work/life balance.

The trust used electronic patient records which provided easy access to results reporting and details of previous contacts with the organisation. This meant that clinicians were well informed of the patients' conditions and could always see the patients with their records available.

The division had a proactive approach to developing and training staff. They identified areas where recruitment was difficult and developed their own staff into these roles. This made staff feel valued and invested in, which enhanced retention of posts.

Nurse staffing levels were appropriate with minimal vacancies and staffing levels met patient needs at the time of the inspection. Staff in all departments were aware of the actions they should take in the case of a major incident.

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Staff had information they needed before providing care and treatment but in a minority of cases, records were not always available in time for clinics.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt

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supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. Consent was obtained before care and treatment was given.

During the inspection, we saw and were told by patients, that the staff working in outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their treatment. Patients we spoke with during our inspection were positive about the way they were treated.

Waiting times for diagnostic procedures was lower than England average and the trust consistently met the referral to treatment standards over time.

There were systems to ensure that services were able to meet individual needs, for example, for people living with dementia. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Staff were familiar with the trust wide vision and values and felt part of the trust as a whole. Outpatient staff told us that they felt supported by their immediate line managers and that the senior management team were visible within the department.

There were effective systems for identifying and managing the risks associated with outpatient appointments at the team, directorate and organisational levels.

Regular governance meetings were held and staff were updated and involved in the outcomes of these meetings. There was a strong culture of team working across the areas we visited.

## Are outpatient and diagnostic imaging services safe?

Good



Overall, we rated the service as good for safe because:

- The division was open and transparent. Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Staff were fully supported when doing this.
- Performance data showed a good track record in safety. When things went wrong, investigations were completed in a timely manner and lessons learnt shared across the division.
- The safety of vulnerable adults was maintained and given sufficient priority.
- Clinic facilities were appropriate to meet the needs of bariatric, reduced mobility and visually impaired patients, with appropriately decorated and equipped areas.
- Staffing levels were planned and reviewed regularly to meet the needs of patients. Shortfalls or pressures were identified and responded to quickly and adequately.
- Staff maintained high levels of mandatory training. All areas had a local induction programme in place to support new staff.
- Senior managers reported minimal vacancies across all areas, with limited use of agency or locum staff. Non substantive staff were inducted to areas and offered the support of a mentor or buddy.

However:

- The domestic services across the trust had been outsourced and cleaning schedules were not available in all clinical areas.
- Some areas within the outpatients and diagnostic services were in need of modernisation.
- Some speciality clinics were planned by the speciality and not the outpatient team, although clinic staff were used to run the clinic.

### Incidents

- There were three serious incidents (SIs) reported through the Strategic Executive Information System (STEIS) in the Outpatients Department (OPD) service between December 2014 and November 2015. Two of

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these occurred in March 2014. One incident related to a delay in diagnosis following test results and the other related to a decontamination error with a piece of clinical equipment (endoscope). The third incident occurred in December 2014 when there was a breach in confidential information. The trust completed investigations into these incidents to highlight any actions that could be completed to prevent reoccurrence. In all cases actions had been taken either with individual staff or through the development of processes to prevent reoccurrence.

- The trust reported one never event the week prior to inspection. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. (Serious Incident Framework, NHS England March 2015). On this occasion the wrong patient was treated in the ophthalmology department. An investigation had been commenced to identify any learning and any actions that should be taken to prevent reoccurrence. On attendance at the clinic, it was evident that shared learning had already commenced. The staff room had a notice board designated to the incident and staff were highlighting actions that could be taken to prevent reoccurrence, and key points regarding what went wrong. Staff on duty were open about the incident and discussed what impact this had on the team including learning on management of similar situations.
- The service used the trust 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. The system identified an individual 'handler' for each reported incident that had responsibility for any follow up action. Staff had feedback on incidents and action taken via staff meetings, team briefings and information on staff noticeboards. Staff working in the outpatient department told us that learning from incidents was fed back via local meetings which were facilitated by the matron or clinical lead.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(MER)) or magnet related events in the last 12 months.
- Each service had an individual risk register which was then amalgamated to produce a divisional risk register.

The majority of risks related to equipment and services, such as bespoke IT reporting systems and increased staffing vacancies. However the clinical leads had plans in place to address the risks, and a replacement programme for IT equipment and laboratory analysers.

- Quality and safety dashboards were produced across all areas to identify compliance with performance targets and safety. These dashboards were produced monthly for reporting and findings cascaded to staff during meetings. Examples of these were observed during inspection.

## Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were fully aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. Serious incidents were managed in line with the Duty of Candour regulation.

## Cleanliness, infection control and hygiene

- All areas we visited, including clinical and waiting areas, were visibly clean.
- In November 2015, 91% of nursing staff and 85.3% of medical staff within the outpatients and diagnostics team were compliant with infection control training. The trust's internal target for this training was 80%.
- Hand washing audit compliance showed 70 to 80% compliance for doctors and 100% compliance for nursing staff. Audits were completed monthly by staff from another department to ensure no bias and results discussed at team meetings to promote compliance and action plans were in place.
- There were daily checks of bins and treatment rooms and a monthly cleaning audit in place. The trust had recently outsourced the domestic services and staff

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reported that despite initial problems, the cleaning was now as expected. The outpatients department did not have an official cleaning schedule; however the Matron was expecting this to be provided shortly.

- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- Cleaning staff were observed using colour coded equipment in line with trust guidelines.
- Toilets were clean and well equipped with sufficient hand washing gels and paper towels.
- 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.
- All staff were observed to be bare below the elbows and wearing appropriate personal protective equipment in the relevant locations and departments, e.g. patient contact, laboratories.
- We inspected eight consulting rooms and noted all had gloves, aprons and handwashing facilities available.
- Clinic rooms used for clinical procedures were adequately equipped to maintain safety and infection control standards.
- We saw all rooms had appropriate facilities for disposal of clinical waste and sharps.
- Spillage kits were available as required. Staff were able to tell us what they would do in regards to decontamination following patients with suspected communicable diseases.
- Imaging rooms were cleaned daily with only radiology staff cleaning the equipment. This was to ensure staff were aware of radiology risks and kept safe.

## Environment and equipment

- The outpatient and diagnostic environments varied across the trust. Some areas had been recently refurbished and modernised; however there were pockets of services which were cramped and in need of attention. The clinical leads told us that a refurbishment programme was underway, with plans to move or amalgamate services to produce a patient friendly environment and improve functionality. The plans included working with an architect to redesign the x-ray

department, amalgamating laboratory space and the removal of offices from clinical areas. Building works had commenced across the organisation, with changes planned to take up to 18 months.

- Some clinic areas provided small rooms and waiting areas which were not appropriate for wheelchair users or bariatric patients. Once this was identified staff on duty would ensure patients were seen in alternative clinic rooms or transferred to a more suitable facility. Patients' dignity was maintained throughout.
- The trust had introduced a "book wise" scheme to identify available rooms across the organisation for clinics. This meant that staff were able to fully utilise rooms to meet the demands of the outpatient clinic lists.
- The breast clinic was situated a short distance from the main site and was designed to meet the needs of the patients and clinicians. The clinical team had been consulted in the design of the unit with the patient pathway in mind. The facility had large consultation and counselling rooms, facilities for diagnostics (x-ray) and a large seminar room for multidisciplinary team meetings.
- The orthopaedic hub opened in November 2015 and was situated a short distance from the main site. The new build was planned to address the large number of patients attending the department and was instrumental in the redesign of the main hospital site. The facilities at the new site were designed in discussion with the orthopaedic clinical director. The facilities included an increased number of clinic rooms, x-ray and plastering facilities and physiotherapy rooms. The established team were responsible for the treatment and care at the new site under the direction of a new manager. The redesign of clinic rooms was to provide a streamlined appointment system with reduced patient waiting times. This was to be achieved by the consultant moving rooms rather than patients, which allowed for additional clinic appointments where the consultant would have previously been waiting for patients to enter and leave the rooms. The rooms had mobile workstations to facilitate electronic records.
- The plaster room within the orthopaedic hub was considered to be too small to facilitate the storage of all necessary equipment. Equipment needs were being reviewed and additional storage being sourced. In addition the facilities within the old site were no longer available which meant that inpatients requiring new plaster casts were treated in their bed spaces.

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- The emergency department had a designated x-ray department on the ground floor, which was easily accessible. This consisted of two imaging rooms which could hold a trolley/ bed and an additional small room for walking/ wheelchair users. This was staffed 24 hours per day seven days a week.
- Clinical leads had devised a rolling replacement programme for equipment across the outpatient and diagnostic areas. This included replacement of existing x-ray and laboratory equipment.
- We were told that there were plans to extend the capacity of services by introducing an additional computerised tomography (CT) scanner and an additional MRI scanner. The CT scanner was planned to be situated in the ground floor x-ray department used by the ED. This would mean that patients with trauma or a suspected stroke would not have to be transferred to the first floor for procedures.
- The maintenance of equipment was completed via either the manufacturers or the trust estates department. A schedule of work was in place and equipment was assessed annually as safe for use. We saw the maintenance logs for all equipment as part of our inspection.
- Clinicians told us that there was sufficient medical equipment to meet their needs, for the number and types of patients seen in the outpatient clinics. Both static and mobile equipment was available to ensure inpatients were seen in a timely manner (for example portable x-ray machines).
- There were systems to maintain and service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- Equipment within the Ear, Nose and Throat Clinic (ENT) was observed to be cleaned appropriately between patients. The scopes were tagged as being dirty and were then transported to the decontamination area within the main endoscopy department via sealed boxes on a trolley. Staff told us that due to the estate the trolleys were pushed through public areas; however there was no risk of cross infection.
- Clear signage and safety warning lights were in place in the x-ray department to warn people about potential radiation exposure.
- The nuclear medicine department had a nominated toileting facility which was clearly labelled as for use by patients only. A cleaning regime was in place for this facility and necessary precautions identified within the cleaning plan.
- We examined the resuscitation trolleys located throughout the departments. The trolleys were secure and sealed. We found evidence that regular checks had been completed. Adult and paediatric resuscitation equipment was available to the teams where services were provided for children as well as adults.
- The imaging departments provided designated male and female changing areas. In the main x-ray department these changing rooms were located on the main corridor and could be observed by other patients in waiting areas. During inspection we noted that there was no designated waiting area for an inpatient on a bed. During our inspection a patient was waiting in the corridor for a short period whilst waiting for the porters to attend to take the patient back to the ward. We were told that the changing and waiting facilities would be addressed during the redesign of the service.
- Due to the size of some clinics patients were observed being weighed and height measured in the corridor outside clinic rooms. Staff were observed maintaining privacy and dignity during these processes.
- Patients attending the hospital had access to visitors' car parking, which was usually a short distance from the outpatient department. There was clear signage to outpatient areas and reception was manned during clinic times to assist with directions.
- Patients complained that there was insufficient car parking for the number of attenders to the organisation, stating that they often parked in nearby roads.
- The breast unit was also part of the national "Art for Health" programme, where by art work was loaned to the unit to decorate the area.

## Medicines

- Outpatient staff told us that they had limited medications available within the departments but could access specific medication if necessary from pharmacy. Staff reported that this was rare due to the appointment system in place and patients often brought their own medication with them, or were not in the department long enough to require additional medication.
- Medicines for treatments and procedures were stored in locked cupboards or refrigerators. Nursing staff held the

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keys to the cupboards so as to prevent unauthorised personnel from accessing the medication supply. There were no controlled drugs or intra-venous (IV) fluids held in the outpatient areas.

- Fridges used to store medications were checked by staff in line with trust 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.

## Records

- Patient records were maintained and stored in accordance with trust policy.
- The outpatient department used a combination of paper medical records and an electronic system. Paper records were maintained for each clinic attendance and then scanned into the patients' electronic record. The diagnostic imaging, pathology and microbiology, diagnostic results were recorded electronically. This meant that patients were always able to be seen when attending the department as the medical records were always available.
- Wi-Fi was widely used across the trust, and minimal problems were identified by staff apart from the urology one stop clinic who told us that they sometimes had issues with signal. However this did not affect patient care.
- The Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was completed for all patients undergoing invasive procedures. Completion of the checklist is audited by the division leads and findings shared with the appropriate teams. Evidence to support this was observed during inspection.

## Safeguarding

- We saw systems in place to ensure the right person received the right radiological scan at the right time. Reception staff told us they confirmed patient details including the area they were expecting the imaging on. If the area of the body differed they would look back to the referral and establish if it was a clerical error or a referral error. We saw radiology staff check details of the areas of the body they expected to be imaged to ensure that they had the correct information before

commencing the imaging process. This confirmed that safe systems were in place to protect patients from unnecessary radiation through referral and clerical errors.

- Staff had regular training in safeguarding of vulnerable adults and children. 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 and relevant contact numbers for safeguarding were seen on staff noticeboards and in public areas. Staff told us of their actions in a recent safeguarding incident and explained that patients attending the department, who were at risk, were normally flagged so additional supervision was provided.
- Training statistics provided by the trust showed that 100% of staff in the outpatient service had completed level 2 safeguarding children and 91% safeguarding adults training. 82% of medical staff had up to date training in Safeguarding Children level 2 but only 79% had up to date training in adult safeguarding. The trust's internal target for this training was 80%. We saw that further training dates were being arranged to address this shortfall.
- We were told that outpatient staff escalated on average one safeguarding referral per month.

## Mandatory training

- Over 90% of nursing staff within the outpatients' service had up to date training in all the mandatory training modules, except for conflict resolution where 63% of nursing staff had completed this module. The service met the trust's 80% target for medical staff completing mandatory training in four out of the seven training modules. Mandatory training covered a range of topics, including fire, health and safety, basic life support, safeguarding, manual handling, hand hygiene and information governance. Training plans were in place.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- We saw completed training workbooks which had been reviewed, dated and signed by senior staff. This meant that staff working across the outpatient and diagnostic services were supported with their local induction. New staff were also supernumerary for a period of time at the commencement of post, the duration of which varied according to the area of work.

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- Departments reported monthly training days which were run in conjunction with the department audit days. The days would include specialist training and team meetings.

## Assessing and responding to patient risk

- Outpatients and diagnostic imaging staff completed risk assessments including national early warning score (NEWS), pre-assessment for procedures and pain assessments. NEWS is used to identify if a patient is deteriorating. In accordance with the trust's deteriorating patient policy, staff used the NEWS to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. These were recorded appropriately in patient records and nurses escalated any concerns to medical staff in clinics.
- The trust had introduced an electronic system to the Haematology department, which tracked blood transfusions processes. Each ward had an electronic device which linked to the porters and haematology laboratory. Once the need for a blood transfusion was identified the laboratory would prepare the unit of blood and then notify the porters when it was ready to collect. The porter would then need to check the unit of blood against the patients' information and transport the unit to the ward. The time of removal from the refrigerator was logged electronically. The nurse then checked the details of the unit and patient to confirm identity. The time of arrival on the ward and the time of commencement of administration were also recorded. This system helped to prevent unsafe administration of blood products and prevented products being administered outside the recommended time frame.
- The trust had identified radiation protection supervisors and we observed these displayed on a list in each department. We observed signs in the radiology department to prevent people entering areas that would place them at risk of radiation exposure.
- 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.
- The Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was in use for patients undergoing invasive procedures and diagnostics.
- Resuscitation equipment was available in the outpatient and diagnostic areas.
- Patient appointments were managed through a central electronic booking system (trust wide) at the contact centre. Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks.
- Triage of new referrals was undertaken by clinicians and once appointments were allocated, priorities were maintained even if appointments/clinics were cancelled (for example, they would be re-booked in the same order of priority unless assessed as more urgent on an individual basis).
- Patient observations were recorded on the electronic patient record. Staff escalated concerns regarding patient's wellbeing to the medical team attending. Staff reported that some patients were directly admitted from the outpatients departments as they often found that patients would wait to see the doctor despite feeling unwell. The admission time for the department was less than four hours from referral.
- There was a protocol in place to manage deteriorating patients and a system was in place to transport unwell patients to the emergency department.
- Administrative staff told us that if a patient collapsed in the waiting area they would press the emergency button to alert other staff. This meant that in the event of a medical emergency appropriate action would be taken to assess and respond to the patients' needs without putting them at risk of deterioration.
- In the event of an emergency remote outpatient areas (those not attached to the main hospital site) used emergency services (999). Each clinical area had appropriate emergency equipment to manage an emergency.
- Radiography staff informed us they were aware of contrast-induced reactions and that they could easily locate the anaphylaxis kit to use should these reactions occur. Staff told us that if anaphylaxis was suspected they would contact the emergency team who would treat the patient appropriately. All emergency equipment was centrally located to enable all areas access.
- Signs in relation to radiation exposure and pregnancy were seen throughout the imaging department.
- Radiographers conducted a check on the pregnancy status of all women of childbearing potential prior to

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imaging in line with national guidance. Pregnancy status checks were audited by the radiation protection advisor to ensure that these were conducted and patients were kept safe.

## Nursing staffing

- There were no baseline staffing tools used in OPD to monitor staffing levels. However observation and interviews with staff confirmed that there were adequate numbers of nursing staff to safely manage OPD clinics. The staffing establishment was being reviewed as part of the staffing consultation to extend working hours and was monitored by the matron. We observed that there were reception and nursing staff available to support all clinics running during the inspection. During the inspection, actual staffing levels met the planned rota for staff needed per area.
- The division leads were in the process of reviewing clinics and staffing required to manage each speciality. Following this a “room rate” would be introduced based on one of three options. Options included; clinic room plus nurse, clinic room plus care support worker, and clinic room plus administration. Once the proposed scheduling had been completed the division would be able to identify the total numbers of staff required for each clinic and therefore adjust total establishment accordingly.
- We were informed that there were no staffing vacancies across the division however a number of posts were recruited to but staff were not yet in place, with start dates predicted for the next three months. To manage the workload the departments used either their own staff working additional hours or regular bank staff.
- The culture of supporting new/ bank staff was evident throughout the department. Health care assistants would assist with the management of the clinic lists and offer support to new staff and new staff were spread across the department to ensure that there were no areas of risk. Staff were provided with mentors and coaches appropriately and regularly worked alongside them to ensure competence.
- New and bank staff were inducted locally using a checklist with an additional competency pack for substantive staff. Examples of these were observed during inspection.
- Staff were expected to work across all clinical areas, however due to additional skills being required for some areas, the same staff tended to be allocated to that

specific area. The matron was responsible for completing the off duty/work plan. The outpatients departments were planning to be transferred to e-rostering in 2016.

- Some clinics were managed by the speciality rather than the outpatients’ team; however outpatients’ staff assisted with the running of the clinics. This was noted as causing some problems to the outpatient team, as the specialities may add additional clinics/ consultants to the day’s activity, but failed to notify the change in need to the outpatients team to amend either room booking/ staffing required to support the clinic. The matron was addressing this issue with the individual specialities. Patient care was not impacted by this as staff escalated the situation to the nurse in charge or matron and additional rooms or staffing changes occurred to meet the demands. This was observed during inspection.
- Sickness was reported across all clinical areas, and we were told that return to work interviews were completed for all staff returning from sickness and staff were managed in line with trust policy.
- Study leave was observed to be covered by planned rostering, as additional staffing was not always available to cover any shortfall in numbers. Staffing was therefore supplemented with bank staff, and training spread across the year to prevent periods of increased numbers of bank staff being used.
- There was a designated nursing sister allocated to the imaging department who worked closely with the team to provide care and treatment for patients undergoing diagnostic procedures.
- Each area within the imaging department had superintendents. This was a senior practitioner who worked with the team to ensure completion of care and training and competence management of staff.

## Medical staffing

- The trust has 40% consultants compared to England average of 39%, and 11% middle career doctors compared to the England average of 9%.
- Medical staffing was provided to the outpatient department by the various specialties which ran clinics.
- Medical staff undertaking clinics were of all grades; however we saw that there were usually consultants available to support lower grade staff when clinics were running.

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- Job planning had been reviewed within the orthopaedic team to ensure that they captured the work in the off-site orthopaedic hub and to ensure that the team were not responsible for new admissions within the main site when working within the clinic.
- All clinicians reported adequate mentoring supervision across all departments.
- The imaging department had extended working hours during the day, but radiology on call was outsourced. The divisional director had been responsible for clarifying the role and responsibilities of the outsourced facility, and this included reviewing the competencies of the team working for them. Overnight CT reporting was outsourced as well as a proportion of routine diagnostics. The division maintained a seven day results reporting profile.
- The clinical leads told us that there was a small number of agency staff across the outpatient and diagnostic teams, to a total of ten individuals. These were spread across all specialities including Radiology, Haematology, Inpatient therapists and the Mortuary. We were told that all of these staff had been reviewed by the lead clinician for that area to ensure appropriate competence and experience was in place and had a formal induction to the area. This was confirmed by individual practitioners.
- There was one endocrinology consultant in post which meant that there could be a delay in referral to assessment times. Trust audits detailed waiting times for endocrinology appointments to be on average three weeks. A business plan had been devised to correct this but the results were not known at the time of inspection.
- All consultants were identified as having completed or in the process of completing revalidation.
- A draft business continuity protocol was in place detailing actions to be taken if an incident occurred which affected either reporting services or any equipment. This was shared during the inspection and was due to be ratified by the trust.

## Are outpatient and diagnostic imaging services effective?

We inspected, but did not rate the service for effectiveness. We found:

- There was a holistic approach to assessing, planning and delivering care and treatment across an established seven day working programme.
- New evidence based techniques and technologies were being used to support delivery of high quality care.
- Staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were pursued across all departments.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Staff and teams work collaboratively to provide innovative and efficient ways of delivering joined up care for patients.
- The division dedicated additional funding to areas of recognised pressures in recruitment to develop their own staff into specific roles.
- Where appropriate National Institute for Health and Care Excellence (NICE) guidance was followed
- At the time of inspection the trust had met all targets relating to waiting times for referrals and treatment.

## Major incident awareness and training

- There was good understanding amongst nursing and medical staff with regards to their roles and responsibilities during a major incident.
- Staff were able to signpost us to the trust wide policy on major incidents which was located on the trust intranet.
- Staff were aware of fire safety precautions and emergency evacuation procedures.

## Evidence-based care and treatment

- The hospital complied with the National Institute for Health and Care Excellence (NICE) quality standard for breast care recommendation that a clinical nurse specialist is present during appointments.
- Policies were in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients

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- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross referenced to national audit levels and if they were found to be high a report to the radiation protection advisor would be made.
- Staff we spoke with 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.
- The hospital's clinical audit schedule outlined when, how often and who would conduct audits in the various areas. These audits included quarterly medication, infection control and resuscitation equipment audits. Examples of completed audits, associated action plans and evidence of completed actions were observed during inspection. For example, equipment identified as not being suitable for clinical areas in the July 2015 infection control audit had been replaced.

## Nutrition and Hydration

- Risk assessments were in place when required.

## Pain relief

- Nursing staff administered simple pain relief medication and they maintained records to show medication given to each patient and effectiveness on the NEWS charts.
- 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 using the NEWS charts.
- Specialist pain clinics were managed by the pain specialist team. The team were also available for consultation via telephone referral.

## Patient outcomes

- The follow-up to new appointment rate at the hospital was 1.8, lower than the England average during the period July 2014 to July 2015.
- Joint appointments were used for patients with complex health needs. This included adolescent and adult clinics, and pregnancy and gestational diabetic clinics. This enabled patients to attend fewer appointments at hospital and receive a streamlined treatment programme.

- The division did not currently participate in the imaging services accreditation scheme (ISAS) or improving quality in physiological services (IQIPS).

## Competent staff

- Staff we spoke with confirmed that they had regular updates on mandatory training and competency assessments and were able to cite recent training in all cases. The outpatients' team compiled a plan in October each year to identify when training was due, and programmed this into staff availability for clinics. The trust had linked increment payments to mandatory training and therefore staff needed to ensure they had completed all relevant training in order to achieve their yearly increment. A reminder was sent to the individual regarding training and their line manager to ensure that they were aware of the necessity to complete the training within a certain timescale.
- Medical revalidation was introduced in 2012 with the aim to ensure that all doctors are up to date and remain 'fit to practise'. All diagnostic consultants were identified as having completed revalidation.
- Staff had regular appraisals which were confirmed by staff interviewed. New staff underwent an induction process and there was a 'buddy' system to support new staff during induction. Induction training included mandatory training, a period of shadowing and a workbook which had to be signed off to confirm competency levels. Examples of these were observed during inspection.
- The trust appraisal policy stated that all staff were required to have annual appraisal using the job description and person specification for their post. Staff that had received an annual appraisal told us it was a useful process for identifying any training and development needs. Trust data for December 2015 showed completed appraisal rates 90% of outpatient staff had completed an appraisal.
- Specialist clinic areas provided additional training for staff to ensure competence in the speciality. Bespoke competencies were in place for each clinic area as well as specific clinical skills required for the specific speciality. For example, staff working within the Maxilla-Facial department were dentally trained and had work experience within a local dental practice to maintain competence. Examples of these were seen during inspection.

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- The trust had an established apprenticeship programme in place. During inspection we spoke with one individual who was on the programme. She told us that the course enabled her to study and work at the same time. The team were supportive and encouraging. Training was provided locally on site and enabled shared learning.
- Staff who were mentors told us that they completed 2 yearly mentor updates to ensure that they had the appropriate skills and up to date knowledge to meet students or new starters' needs.
- Staff that were not formally trained in radiation administration were assigned to mentors throughout the diagnostic department and practice was supervised. This was in line with legislation set out under IR(ME)R. Students were observed being supervised during inspection and competencies completed to record skills learnt.
- The matron for outpatients and diagnostics told us that the trust had provided appropriate training and development for the matron role, and encouraged the use of a coach to promote further development.
- Patients who attended outpatient clinics and the diagnostic imaging department told us that they thought the staff had the right skills to treat, care and support them.
- The diabetic services had commenced weekly drop in training session with junior doctors to support their knowledge and understanding of the condition. This ran parallel to the training given during medical trust induction.
- Assistant Practitioners were used widely across the orthopaedic and breast screening clinics as the specialist roles enabled development of clinical competencies under the support of specialist nursing/therapeutic staff. Examples of these were seen during inspection.
- We saw evidence that the trust was proactive in developing staff. Staff throughout all departments informed us of the trusts and divisions dedication to developing individuals' clinical practice to ensure sustainability of services.

## Multidisciplinary working

- Clinical leads told us that there were excellent working relationships between diagnostic staff and clinical

- teams. An example of joint working was the microbiology laboratory staff attending ward rounds in clinical areas. This enabled development and understanding for both clinicians and laboratory staff.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- 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.
- The diabetic specialist nurse's told us they attended daily ward rounds to ensure appropriate insulin regimes were in place for patients and to assist with planning treatment for discharge and possible re-attendance as an outpatient.
- The diabetic services had commenced weekly drop in training sessions with junior doctors to support their knowledge and understanding of the condition. This ran parallel to the training given during medical trust induction.
- The diabetic nurses were in the process of formulating a teaching programme which would be completed trust wide to assist with the management of diabetic patients.
- Notice periods for clinical staff had been extended to 12-16 weeks depending on the grade of role. This was changed to allow additional time for the post to be recruited into before the individual left the organisation.
- We were told that all specialities held weekly multidisciplinary team meetings to discuss workload and treatment plans. These were reported as being well attended and valuable to learning.

## Seven-day services

- All diagnostic teams had a robust seven day service in place with extended working hours to meet clinical demands. This includes the echocardiogram (ECHO) department, MRI, CT scanning, Nuclear Medicine and laboratories. The facilities were open from 8am to 8pm (9pm MRI) Monday to Friday and 8am to 6pm at the weekend. Clinical leads told us that staff worked shift patterns to suit the needs of the departments, and extended working days to ensure that any emergencies were seen within recommended timescales.

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- The outpatients' clinics were open Monday to Friday 8am to 5.30pm, with extended clinic times on Tuesday. Staff had been working additional hours to provide a Saturday outpatient clinic service. Staff had been recruited into the service to enable two regular evening sessions and Saturday services.
- Staff reported that to prevent admitted patients with new onset of cardiac conditions waiting for outpatient appointments; the cardiology team performed diagnostic procedures whilst they remained in hospital. This was not policy or requirement and completed as goodwill.

## Access to information

- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the electronic system.
- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance, and e-learning.
- Diagnostic imaging departments used the picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Staff used systems to check outstanding reports and staff were able to prioritise reporting and meet internal and regulator standards. There were no breaches of standards for reporting times.
- There were systems in place to flag up urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.
- 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.
- There was a secure image exchange portal transfer of information between local NHS trusts and the hospital. This meant that images were shared between providers to prevent unjustified re-imaging of patients.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

- Consent for care and treatment was usually managed by individual specialist departments rather than the OPD. The trust 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, one for children and another for procedures not under a general anaesthetic.
- The division completed regular audits of verbal and written consent. The verbal consent audit in breast screening completed in November 2015 showed that 84% of cases had recorded verbal consent. This information was shared with the medical team and continuing audits planned to identify improvement.
- Staff said that they had had some training in MCA and DoLS as part of their safeguarding training. Trust wide compliance with MCA and DoLS training was 87% above the trust target of 80%. Nursing staff were able to give examples of previous escalation of concerns and completion of safeguarding referrals.
- Nursing, diagnostic imaging, therapy and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. Verbal consent was gained as a minimum prior to any diagnostic procedures.
- 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. Leaflets were available regarding specialist conditions and procedures. Information leaflets were not available in non-English although all departments had access to telephone interpreter services.

## Are outpatient and diagnostic imaging services caring?

Good



Overall, we rated the service as good for caring because:

- Patients were treated with dignity and respect.
- Feedback from patients and those close to them was positive about the way in which they were treated.
- People were treated with dignity and respect and kindness during all interactions.

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- Patients were involved in their care and decision making processes. Staff spent time talking to patients and those close to them.
- Staff anticipated patient's needs, respecting privacy and dignity.
- Patients' appointments were seen to be flexed according to the needs of the individual. This included moving to allow work, child care and other appointments to take place.
- All staff were observed to be kind and caring.
- The trust had a high response rate to the friends and family test with high levels of satisfaction across the clinical areas.

## Compassionate care

- All staff were kind, compassionate and caring in all patient interactions that we observed. We observed good examples of caring and considerate staff during our visits in all areas of the OPD in waiting and treatment areas and in other communal areas such as corridors.
- We observed staff knocking on doors before entering clinic rooms. Patient's dignity and privacy was respected at all times.
- Patients we spoke with in radiology and outpatients praised the staff for the level of compassionate care they provided.
- Patients were provided with the option of being accompanied by friends or relatives during consultations.
- The ophthalmology clinic had a volunteer who provided a hand holding or companionship service for patients who were particularly anxious.
- We observed a good rapport between patients, reception and nursing staff.
- The trust commenced recording the Friends and Family Test in Outpatients in April 2015. The questionnaire assesses whether patients would recommend a service to their friends or family. Between April 2015 and November 2015 results consistently showed an average 95% of patients would recommend the service to their friends and family. This is better than the national average of 92%. Divisional leads reported a high number of responses monthly and findings are shared with teams and displayed on department notice boards.
- All patients spoke positively about their experiences within the departments. Staff were seen to provide

support and assistance where needed and patients did not feel rushed. Patients told us that they had attended the same clinic for a number of years and always received good care. We were told "nothing was too much trouble", "the best thing is the attitude of the staff, from receptionist to consultant" and "all hospitals should be like this".

- Staff were seen to be competent and ready for appointments and often assisted patients to move appointments to suit their individual needs or commitments.

## Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment.
- Patients understood when they would need to attend the hospital for repeat investigations or when to expect a repeat outpatient appointment.
- Where some patients had presented with complex conditions, they told us that nursing staff were available to explain in further detail and in a manner which they could understand, any amendments to their treatment or care.
- Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- Patients said they were kept informed of the clinic waiting times and clinics announced waiting times at regular intervals to keep patients informed.
- Patients were able to be escorted by their relatives or friends if they wished.
- Nursing staff reported telephone interpreting was used more widely than an "in person" interpreter. Clinic telephones could be fitted with an additional handset to enable a three way conversation between patient, interpreter and clinician.
- Patients were provided with copies of correspondence with their GPs.

## Emotional support

- Patients told us that they considered their privacy and dignity had been maintained throughout their consultation in outpatients.
- Staff had good awareness of patients with complex needs and those patients who may require additional

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support should they display anxious or challenging behaviour during their visit to outpatients. Some clinic areas had volunteers who would assist to keep patients company during their appointments.

- There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and carers.
- We were told that counselling appointments were arranged to coincide with breast screening appointments to assist with any distress or anxiety.

## Are outpatient and diagnostic imaging services responsive?

Outstanding



Overall, we rated the service's responsiveness as outstanding because:

- Services were tailored to meet the needs of individuals and offered flexibility in choice with appointments being flexed across a seven day service.
- Waiting times for diagnostic procedures was lower than England average.
- The trust consistently met the referral to treatment standards over time.
- Patients' individual needs and preferences were central to the planning and delivery of the services.
- The division was working to repatriate services to enable patients to be diagnosed and treated locally.
- The division included other organisations and commissioners in planning services to meet the needs of the local population.
- The division had a systematic approach to working with other organisations to improve care and outcomes, including commissioners and manufacturers.
- Weekly monitoring of waiting lists was completed by the division and clinics flexed to meet any changes in demand or noted increased numbers.
- Systems and services were designed to enable effective use by patients who were vulnerable or had complex needs.
- The commissioning group were involved with the development of services to meet local population and individual patient needs. This included the trust acting as referral centre for specialities including breast screening and bariatric services.

- The trust laboratories had completed appropriate laboratory accreditation including Clinical Pathology Accreditation (CPA), International Standards (ISO/IEC 17025), MRA Mutual Recognition Accreditation to identify the standards and quality of services.
- Patients could access the service at times to suit them.
- The division leads reviewed complaints, responded appropriately and developed improvements to prevent reoccurrence. Informal complaints from patients centred predominantly on poor car-parking
- The division had a proactive approach to training and developing staff to meet shortages

However, we found that:

- The proportion of clinics where the patient did not attend was higher than the England average.

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

- The division reported that the clinical commissioners attended the outpatient department quality meetings and assisted with the feedback of projects and developments that affected patient pathways and care. Minutes from these meetings were observed during inspection.
- The outpatient and diagnostic teams offered bespoke appointments for patients. All departments described flexibility in services to meet the patients' needs. This was particularly evident in the breast clinic, where all investigations were planned for one appointment, including scanning, biopsies and discussions with clinicians. This meant that patients would only need to attend the hospital once to gain a diagnosis and discuss a treatment plan. We were told that results from biopsies were available within one week of the biopsy undertaken and patients would receive their diagnosis and confirmation of a treatment plan within that first week.
- We were told that where possible joint clinics were held for patients. This included joint elderly care and diabetic clinics, paediatric to adult diabetic clinics, and oncology and urology clinics. The joining of clinics ensured that patients had a reduced attendance at the hospital but also ensured that the patients and staff were aware of treatment programmes and pending investigations.
- All diagnostic services had an established seven day working pattern. This enabled patients to be seen at appointments to suit their needs.

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- We were told that clinic numbers and waiting times were reviewed weekly and additional clinics were held for specialities with a noted rise in waiting times. This included weekend and evening appointments in addition to normal service.
- Some telephone clinics were available within specialities such as gastroenterology and breast services. These related to follow up appointments following investigations such as biopsies. The patient would choose to have a telephone appointment to discuss results and confirm next steps in treatment plans. Medical staff reported that telephone appointments were particularly popular for patients traveling a distance.
- The division planned to introduce “self-check in” as the next phase of clinic development. This electronic system allows patients to select preferred language, and check appointment letter details and identity prior to clinic appointments. This project had been placed on hold whilst the trust updated their Patient Administration System (PAS) which is a system for monitoring patients across the organisation.
- The Emergency department had a designated x-ray facility situated on the ground floor. This area was managed by the imaging and diagnostic teams and offered a 24 hour service specifically for ED. This meant that patients could be processed through the department in a timely manner and that patients attending for outpatient appointments were not disrupted by patients attending the ED.
- The CT scanner was situated on the first floor. Any patients attending the ED who required a CT scan would be slotted into the day’s list to ensure that they were seen as an emergency. The staff reported that there was limited disruption to services, however they were planning to obtain a third CT scanner which would be located on the ground floor next to the ED. The business plan for this was awaiting approval.
- The orthopaedic hub had been designed in conjunction with the clinical team. The design included increased numbers of clinic rooms and reduced desk space. Two clinic rooms enabled doctors to see patients in quicker succession increasing productivity as they did not have to wait for patients to enter or leave the clinic rooms. The clinical lead suggested minimal desk space was required as all patients’ notes were held electronically, and therefore no desk space was required for writing.
- We were told that the urology clinic provided drop in sessions for patients who were attempting to have their catheters removed. The sessions allowed any patient with a catheter to drop in for assistance or advice regarding the management of their catheter.
- The division had commenced the repatriation of services from other trusts to the main site to improve the services provided for patients. This included some blood sampling in immunology which was previously completed outside the organisation. The service had been developed by the laboratory staff and was supported in clinical practice by a visiting consultant on a weekly basis. This meant that patients did not have to travel to London for appointments and blood results were available much sooner.
- The trust has implemented the review of the outpatients’ facility as part of the service improvement programme. The division identified that orthopaedic and ENT clinics were regularly busy and over ran due to delays in processes. The service improvement facilitator reviewed data and attended clinics to observe where the system could be improved. They identified that the previously used appointment scheduling system did not recognise the need for appointments for different parts of the clinic, and booked appointments for each time slot accordingly. This meant that for example, the two consultant appointments and two audiology test appointments for a specified time may be booked with four patients to see the consultant, generating a delay in the clinic. To address this, the trust had implemented a clinicians screening system to the appointment scheduling. This ensured that patients were referred to the correct part of the clinic.
- The breast screening service offered mobile screening across the catchment area in a planned three year cycle (this included Bedfordshire, Hertfordshire and Buckinghamshire). This enabled patients to be seen locally and not travel to the main site for initial screening.
- The trust provided mobile retinal screening services in the community with equipment being placed in GP practices to enable all patients to be seen locally and prevent travel to the main site.
- The elderly care outpatients clinics offered a variety of services to meet the patients’ needs. Patients could

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access a number of the clinics at one time to ensure that they receive the appropriate level of care. The clinics included sessions on falls, movement disorders, cardiology, plus general clinics over a five day service.

- The diagnostic service had a dedicated paediatric list on a weekly basis. The appointments were longer and managed jointly by the paediatric team and diagnostic staff. Patients were able to be brought to the department with their parents and staff from the wards to ensure that they were not exposed to further anxieties. Diagnostic areas were appropriately decorated with children's characters to assist with them feeling comfortable. Some waiting areas, such as MRI had play facilities or activities for children, but this was not consistent across all outpatient areas.
- Patients attending ophthalmology outpatients' clinics were informed of the possibility of lengthy appointments in the appointment letter. Lengthy appointments were due to the large number of treatments or investigations required at each appointment for example eye test, retinal screening, visual field test and appointment. Nursing staff found that if patients were informed of this prior to appointment, patients were prepared for the time spent in clinic. The clinic scheduled on average 70 to 100 patients per morning or afternoon session. The clinic facilitated sufficient rooms and appropriate length appointments for new and follow-up patients.
- We were told that patients attending outpatient's appointment found to have a suspicious mass would receive a diagnostic biopsy on the same day. This prevented any delays in diagnosis.
- Service managers held weekly meetings to plan for the weeks ahead. They discussed each clinic taking place, previous performance in terms of appointment utilisation and over runs and highlighted concerns such as patient numbers or cancellations.
- The division was used as a reference centre for other organisations developing an electronic room booking system. The system used enabled central management of appointment scheduling to maximise room utilisation.
- The division had participated in a peer group review arranged by an external company. This review included six organisations who attended each site to observe practices and discuss methods of improving services.

The division leads had used information gathered from peer reviews to identify areas of good and could be improved practice and found that they were in line with the other trusts.

- The diagnostic imaging department had processes in place and the capacity to deal with urgent referrals and arranged additional scanning sessions to meet patient and service needs.
- Additional clinics were arranged for patients with specialist conditions such as sickle cell anaemia as required.
- We were told that the diabetic team worked closely with community providers to ensure that the transition of care was not problematic. The trust had a large number of patients who receive their insulin therapy via a pump, and had designated clinics for these patients to ensure that patients were receiving the optimum treatment for the condition.
- The outpatient and imaging departments were sign posted from the entrance of the hospital and all areas were within a short walking distance. Signage around the outpatient and diagnostic imaging department was in English only. We saw staff stopping to ask patients and visitors if they required assistance or directions if they saw them appearing to be lost.

## Access and flow

- Between December 2014 and November 2015, the trust consistently met the 95% non-admitted referral to treatment standard that was in place until June 2015. The trust met the standard for referral to treatment time (RTT) for incomplete pathways between December 2014 and November 2015 and was also consistently above the England average.
- The trust consistently met national cancer targets regarding referral to treatment times between December 2014 and November 2015. This included patients being seen within two weeks of referral from GP, the 31 day diagnosis to treatment time and 62 day GP referral to commencement of treatment target.
- Between December 2014 and November 2015, the division consistently performed better than the England average with diagnostic testing being completed within six weeks of referral.
- In November 2015, 83% of patients were seen within 30 minutes of their scheduled appointment time.
- Between 2 to 3% of all clinics were cancelled per month for appointments within six months (between June 2015

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and September 2015), with an additional 2% of clinics being cancelled over six weeks from appointment date. This is lower than the national average. The main reasons for cancellation of clinics were consultants booking study leave or annual leave and rotas or job plan changes.

- The proportion of clinics where the patient did not attend was 9%; higher than the England average of 7%. The division had plans to develop appointment scheduling to include an appointment reminding system which contacts patients in advance by the patients preferred method. Preference would be established during first contact and could be set to the individual preference of either automated text, automated telephone call, or in person call. Implementation was planned to be completed by end 2016.
- The division had implemented “SMART” appointments. This was a computerised process where patients’ previous attendances at hospital were reviewed and a probability of attendance ascertained. This meant that patients with a history of non-attendance were scheduled for the same appointment slots as others who were unlikely to attend. This process enabled patients to be seen if they did attend the department, but also meant clinic productivity was not affected for prolonged periods by non-attendance. This process was trialled within the breast screening service and was being monitored for effectiveness by the clinical leads.
- The division had piloted partial booking for clinic appointments. This system allowed patients to book appointments within a time scale and to a time slot that suited their individual needs. The trial had increased attendance at clinics. To assist with the development of this across clinics the division had introduced co-ordinators who were responsible for the development and monitoring of the system. The division’s aim was for a “did not attend” rate of less than 8% by the end of 2016.
- The trust operated an open access referral service for GPs for echocardiograms. The referrals were printed on the electronic investigation request cards and picked up by the department. The referral waiting time was approximately four weeks; however we were told that each referral was assessed on priority basis. The team had two nurses dedicated to the procedure and provided a seven day service. Working hours were extended to increase productivity when demand was particularly high.
- The urology one stop clinic opened in September 2014 and offered a variety of services including urodynamic testing, cystoscopy and lithotripsy between 8am-6pm Monday to Friday. The service had dedicated CT slots which were used for all patients with haematuria (blood in urine) as well as more complex diagnosis and treatment. The Urology specialist nurses attended the ward round for inpatients to assist with any specialist advice and follow up service. The five steps to safer surgery check list was used across all departments when conducting invasive procedures and investigations. The environment facilitated division of male and female patients.
- The ophthalmology clinic offered an acute clinic daily between 8am to 8pm. This was accessible for patients with a suspected injury and was accessed via the Emergency Department (ED) or GPs. The weekend and out of hours service was supported by the on call ophthalmologist.
- The outpatients’ matron informed us that clinics for the same or next day were usually arranged by the consultants’ secretaries, and would be dependent on patient needs.
- We were told that the outpatient sister completed a round of all clinic areas at 4:30pm to identify if any clinics were running late. Following this staff were redeployed to assist with the flow and activity of the pressurised area to enable clinics to run or finish on time.
- No excessive waiting times were observed during our visits and all clinics displayed current waiting times on a noticeboard in the waiting area of each clinic (and staff regularly announced the waiting times to patients). Waiting times seen were about 20 to 30 minutes.
- Patients requiring an investigation following an outpatient’s appointment were generally facilitated on the same day.
- We were told that elderly patients travelling to their appointments via public transport were given early appointments to enable travelling in daylight
- The biochemistry department had recently completed a consultation to extend working hours and include nights. The clinical lead had identified several possible rotas for the consultation and the team voted on which

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was most suitable to use. The new rota's had been implemented following completion of the consultation, however due to a number of maternity leaves; the work schedule had not been completed as originally planned producing an increased number of night shifts to be worked by individuals. In response to concerns raised by laboratory staff regarding the number of night shifts worked, the department was in the process of employing locum staff to reduce the number of nights worked. Service delivery was not affected by the changes to working.

- Separate male and female changing facilities were provided for patients.

## Meeting people's individual needs

- All diagnostic services had a robust seven day service in place and patients were able to change appointment scheduling to suit their needs.
- Staff were observed to move patients' appointments to suit the patient's needs. This included appointment scheduling around childcare, bus timetables and work. Nursing staff reported that patients were asked to notify the clinic nurse if they left the waiting area for a comfort break, to prevent their appointment being missed.
- Services were able to provide streamlined appointments to ensure that patients requiring multiple investigations were seen where possible on one occasion. This enabled patients to attend the hospital for one appointment, receive their investigation and then obtain a diagnosis within seven days.
- The diabetic service allocated pumps for the administration of medication based on the individual needs of the patient. The trust had not restricted funding to the service, and therefore any patient who would benefit from the provision of a pump, was discussed at the multidisciplinary team meeting prior to commencement on the programme. The diabetic specialist nurse completed pump clinics to provide training for patients to ensure that they were able to safely manage their treatment.
- Specialist nurses (such as haematology and diabetic) completed outpatient lists to provide care and treatment for patients known to their service. This enabled easy access to support and advice for patients with specialist conditions.
- A translation line was available and there was a range of relevant patient leaflets available in clinic waiting areas, although all were in English. All departments reported

having multi-lingual staff and therefore found that communication was never a problem for patients whose first language was not English. Outpatient telephones enabled a third handset to be added to allow a three way conversation with patient, clinician and interpreter.

- Staff were aware of how to support people living with dementia and had accessed the trust training programme in order to understand the condition and how to be able to help patients experiencing dementia.
- The dementia butterfly scheme was in use within the outpatients department. The system uses a butterfly symbol to help staff identify patients at risk so they can implement measures to address this. For example, ensuring that they are accompanied to their appointments, transport called for them, and assisted to the bathroom if necessary.
- The outpatients' team had dementia champions in place that assisted with the training of staff in the department and offered assistance and advice on how to assist those living with dementia.
- Patients with learning disabilities and those living with dementia were seen to be fast tracked through the department to prevent any additional anxiety of waiting.
- Patients with a learning disability or those living with dementia were fast-tracked through the clinics and had longer appointments scheduled to enable full explanations and support to be given. Any patient attending the clinic for the first time and then identified as having a learning disability or living with dementia were flagged in the patients records, so their next appointment could be fast-tracked as necessary. This system enabled staff to ensure adequate time was allocated for the appointments and to ensure staff were available to assist if necessary.
- The outpatient departments had considered patients living with dementia and the visually impaired to include appropriate signage, calming and defined decoration and clocks.
- Hearing loop was available within outpatients departments
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- The trust offered the regional Bariatric service for patients aged 18-70 years. The catchment area covered Cambridgeshire, Norfolk, Suffolk, Essex, Hertfordshire,

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Buckinghamshire and Bedfordshire. The service consisted of two tiers of service. The first (classed as tier 3) offered medical care and assessment, and the second (tier four) offered surgical procedures. The service had approximately 25 referrals per week and appointments were offered within 8 weeks of referral. The process of treatment was lengthy with patients being cared for in tier three for 4-6 months and then a further 9-12 months for tier four. The service had a large drop out of patients. This had been reviewed and deemed to be as a result of travel time. The bariatric clinic offered a weighing service for other clinics and due to the location of the building offered private rooms for clinicians.

- The breast screening service at Luton and Dunstable hospital was the second largest facility in England. The team had a three year programme which screened approximately 244,000 patients across Bedfordshire, Berkshire and Hertfordshire.
- The breast unit had two entrances for patients, one entrance for those attending for screening and another for symptomatic patients. This enabled patients to be separated in waiting areas which was noted to assist with reducing patient anxiety.
- Male patients attending the breast screening unit also shared the waiting areas. Staff explained that male patients were not identifiable as most female patients brought partners to their appointments, and therefore males were not extraordinary in the department.
- The plaster technicians told us that they no longer had a designated room on the main site for completing plaster cast renewals. This meant that patients were seen on the ward. There were limited storage facilities for the equipment required for this service. This had been escalated to the line manager and would be reviewed as part of the estate review.
- Appointments in the radiology department were booked by the estimated time the imaging would take; this meant that appointment lengths were tailored to patient needs.
- The outpatient reception area allowed patients to speak to a receptionist without being overheard and signs requested that further patients wait to be called forward to allow this.
- Outpatient clinics had an additional unregistered nurse available who accompanied patients with poor mobility or visual impairment if the patient consented.

- Snack boxes were available for patients who experienced lengthy appointments or waits for transport.
- Oral hydration and snacks were available in the eye clinic, with water coolers accessible to the remaining clinic areas.
- Nursing staff told us that patients wishing to obtain refreshments generally attended the hospital cafe and notified them of their movements to prevent their appointment being missed.
- Car-parking costs were in line with Department of Health NHS car-parking management: environment and sustainability 2015 advice, offering concessions for disabled patients.
- The x-ray department was located on the first floor of the hospital and on a main corridor. This meant that patients were waiting in areas that were passed by the public as they attended other areas of the organisation. During inspection a patient was observed waiting outside the x-ray department in a bed, whilst patients and their relatives waited in the corridor. Privacy and dignity was maintained throughout the wait for porters. The department had designated porters to assist with the fast-tracking of patients through the department. This enabled patients to be transported to their ward as quickly as possible after the diagnostic procedure had been completed. The team recognised that this was not acceptable; however the estates limited their ability to address this fully. We were told that the trust was in the process of planning the department, and an architect was due to attend the trust to map out a better environment.
- The x-ray department provided male and female changing facilities. During inspection it was noted that a female patient was in the changing room whilst male patients and relatives were in the corridor. Dignity was maintained due to cubicle doors being present and the patient did not consider this to be an issue. Dignity was also maintained when the patient transferred to the imaging room by staff clearing the corridor.
- Staff ensured patients accessed information leaflets on clinical conditions which were widely available throughout clinics.

## Learning from complaints and concerns

- There were 69 complaints regarding all outpatient and diagnostic areas between November 2014 and December 2015. Themes included communication

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issues (including challenges to clinical diagnosis), delays in appointment scheduling, clinic waiting times and follow-up appointments not being arranged as expected by the patient. Evidence of learning from these concerns was evident.

- Performance data showed that in October 2015, 100% of complaints were closed by the division within timescales, in line with trust policy.
- Patients were given advice of how to contact the Patient Advisory Service (PALS) or use the Friend and Family Leaflets for formal and informal complaints.
- Feedback captured through friends and family testing was sent to departments. Senior staff told us that the trust forwarded details of concerns via email and requested confirmation of actions or comments to prevent reoccurrence. The detail of feedback was discussed with the team during meetings and displayed on department whiteboards. During inspection we noted that the outpatients department displayed the number of positive, negative comments and common themes.
- Staff told us that compliments were shared locally and across the trust via the intranet. The intranet provided details of comments (positive and negative) across the trust for all staff to access.
- Information was accessible on the trust website and also throughout the hospital which provided details of how patients could raise complaints about the care they had received.
- Older patients relying on transport were given earlier appointments to ensure they get home in the day light. Staff reported that patients' families were informed of any delays to ensure they do not worry about the whereabouts.
- Staff told us that patients commonly complained about car park facilities or the provision of transport and the delays experienced in pick up from the departments. In response the trust had created an additional 365 car parking spaces over 2014 to 2015 by moving staff parking off site and securing rental of spaces within walking distance. Additional parking requirements were being addressed as part of the hospital development.

## Are outpatient and diagnostic imaging services well-led?

Outstanding



Overall, we rated the service as outstanding for being well-led because:

- The division had leadership, governance and a culture which were used to drive and improve the delivery of quality person-centred care.
- The division had a challenging and innovative strategy that supported the trust vision. This included redesign of departments, introduction of support systems to improve performance and repatriation of services to improve patient experience.
- Divisional leads had a shared purpose and motivated staff to deliver services and succeed.
- Governance and performance management were proactively reviewed and reflect best practice.
- Staff support and collaboration across all functions to improve quality of care and patient experience was evident. Audits and system reviews are used to ensure compliance.
- There was a proactive approach to seek out and embed new and sustainable models of care.
- Clinical leads were visible within each area. Senior clinicians were widely available across all departments to offer support and guidance.
- There were high levels of staff satisfaction, and individuals were proud to work for the trust
- Staff told us that the trust had a proactive approach to training and development, and access to further training was always granted if relevant to the clinical speciality worked in.

### Vision and strategy for this service

- The division had a strategy that supported the trust vision. All staff we spoke with demonstrated an understanding of plans to develop both within division and across the hospital and what was required to enable the process to be completed. A strategic plan was in place and reviewed for progress during monthly divisional meetings.
- The division had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.

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- Clinical commissioners and members of the non-executive board attended the outpatient quality meetings to ensure vision was shared.
  - The division had a strategy for the introduction and continued use of efficient and effective working using information technology such as electronic records.
  - The division was working towards the repatriation of clinical services to improve patient pathways. This included the repatriation of blood sampling for specific immunology screening, and the repatriation of some cardiology investigations. The clinical leads were in the process of identifying further developmental needs such as vascular surgery to improve patient experience and services available at the trust.
  - We were told that the redevelopment of the hospital was enabling updated and cost effective equipment to be sourced in the laboratories and imaging departments. This enabled services to expand and complete new tests which were previously completed within other organisations.
  - There were no vascular services available within the trust and patients were referred to another local hospital for appropriate treatment. Staff reported that access and support was very good. We were told that the trust was looking to repatriate some vascular activity in the future.
  - The division were in the process of implementing a room recharge rate for all clinics. The rate was dependent on services required and based on a room plus un-registered nurse, room plus administration or room plus qualified nurse. This was devised to ensure clinics were being utilised as efficiently as possible.
  - The division was liaising with manufacturers to identify any efficiency in sequencing of investigations to increase activity. This was demonstrated in the x-ray department where an increased scheduling reduced investigation time by 0.2% per appointment, which meant that an additional 40 patients could be seen across the department per week.
  - The division were planning to achieve accreditation in the radiology department over 2016 to 2017.
- The division was split into two specialities; diagnostics and therapies, and pathology, and both groups report into the clinical operations board and the trust board. Information shared up to and down from the trust board included any changes in policy, risks and any incidents and learning. Minutes from these meetings were reviewed as part of the inspection and found to be comprehensive.
- Nursing staff across the outpatients departments told us that they have weekly team meetings in addition to the multidisciplinary team meetings. Minutes of meetings were observed during inspection and found to be comprehensive.
  - The divisional director told us that the trust also had a clinical safety and quality team that reviewed information being shared with the trust board regarding governance and offered advice on learning and the validity of actions being taken. The group consisted of clinical specialists who reviewed incidents and risks to identify learning and guidance on best practice or national guidelines.
  - All staff within the diabetes team attended all meetings including business planning. This meant that all staff were aware of the plans for development of services, the cost of the service and where the funding would be sought. This enabled staff to have a clear understanding of the service and the pressures faced for future development.
  - The division had an active risk register in place, which was reviewed locally and at board level. Elevated risks included aspects such as staffing vacancies, equipment requiring replacement, IT systems and retention of staff. There was evidence to suggest that the risk register was reviewed and discussed at the divisional board meetings. Actions taken regarding risks were clearly recorded.
  - Risk registers were reviewed during inspection and found to be updated regularly and reflected the risks staff told us they were concerned about. Outpatient issues fed into divisional governance meetings where incidents and risks were discussed. Staff received feedback from these meetings from their direct line managers.
  - The laboratories had clinical pathology accreditation (CPA) in place which is an internationally recognised standard of requirements for quality and competence.
  - The imaging department had been assessed by the radiology protestation committee in November 2015
- Governance, risk management and quality measurement**
- The division had a robust governance structure in place with divisional meetings taking place monthly. The information shared varied but followed a set agenda.

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IR(MER). The assessment determines if a department meets regulatory standards in the safe management of ionising radiation which is used to complete x-rays. This ensures that patients and staff are not over exposed to the agents. The review highlighted areas for improvement in quality assurance monitoring in general x-ray, mobile x-ray and fluoroscopy machines. Evidence of this being discussed with the team was observed during inspection and actions taken place to ensure completion.

- Outpatients departments had regular team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend these meetings, steps were taken to communicate key messages to them which included e-mails and minutes of the meetings being available on the staff notice board.
- Individual specialist nurses told us that they reviewed trust wide incidents relating to their speciality to ensure that there were no additional training needs required for individuals or groups of staff.
- The division had devised an annual audit calendar and completed audits at regular intervals looking at topics such as waiting times, consent, hand washing technique, waste and the environment. We saw completed audits and any action plans formulated as a result of the findings during our inspection. For example, waiting times were audited in the ECHO department in November 2015. The results showed that of 15 patients reviewed, six were seen before appointment time; seven within six minutes of appointment time and two did not attend. The auditors plan included repeating the audit twice monthly and sharing findings at the next team meeting.

## Leadership of service

- The service was managed by the Diagnostic, Therapeutic and Outpatients division. The division had a nominated divisional director and pathology director, divisional general manager and divisional matron. They were supported by lead clinicians and managers in all areas of the service including blood sciences, outpatients, dietetics and imaging.
- Each clinical area had a nominated lead that worked and managed the clinical speciality. For example, in the

imaging department each section had a superintendent who was a senior clinician and able to offer support and advise to the team. This ensured that staff had access to clinical experts at all times.

- All staff reported that leadership within the department was very strong, with visible, supportive and approachable managers. All felt that there was a positive working culture and a good sense of teamwork and good staff morale was evident.
- Staff we spoke with all reported that they felt motivated to perform well and were committed to the service provided to patients.
- We saw evidence that the division was proactive in the future planning and development of staff. This was particularly notable in those areas which were traditionally under resourced such as sonography. The division had developed a fully established team with plans in place to continue to develop the department and the individual staff members.
- There were clear lines of responsibility and accountability.
- Staff told us that local leadership was good. Staff felt involved and keen to improve systems and processes to ensure patients received the best care. Staff told us that changes had been made as a result of suggestions they had made.
- Staff felt that they could approach managers with concerns and were confident that action would be taken when possible. We observed good, positive, and friendly interactions between staff and local managers.
- Staff felt that line managers communicated well with them and kept them informed about the day to day running of the departments and were regularly visible in each area.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development. Staff were able to access training and development provided by the trust and the trust would fund justifiable external training courses. The outpatients' matron also received coaching and training for her role to ensure competence and career progression.
- Staff told us that they knew the executive team, they were supportive of new ideas and change and sent out regular communications to staff. Staff also attended biennial trust listening events and stated that these helped to understand the trust vision and plans for the future.

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## Culture within the service

- Staff were proud to work at the hospital. They were passionate about their patients and felt that they did a good job.
- Staff were overwhelmingly positive about their support and development within the organisation. Staff told us they had access to any training relevant to their speciality and this encouraged them to stay at the hospital.
- Staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their teams and suggest changes.
- Outpatients and diagnostic imaging staff told us that there was a good working relationship between all levels of staff. We saw that there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.

## Public engagement

- Friends and Family Test feedback forms were available for patients in clinic waiting areas. In December 2015, the outpatient's department had received over 1200 responses from patients and relatives. The percentage of patients that were happy with the service received and would recommend it was 93%.
- All patients and relatives we spoke with were positive about the service and the care received by the clinical teams.

## Staff engagement

- Outpatient staff had completed a customer care workshop and developed their own department strategy called CARE. This detailed the joint aims of the department as being communication, advocacy, reassurance and empathy with details on how this could be achieved. This was displayed in large poster format within the departments.
- Staff told us that they attended events held by the trust and that they felt they were listened to by the senior management and that the events as beneficial to team building.

- The trust newsletter which was distributed throughout the hospital to update staff on current issues and future plans.
- Staff told us that there were plans to increase the number of OPD clinics in the future across the service to offer more clinics in the evenings and at weekends. The consultation had been completed and staff recruited to the additional posts, however the clinics had not routinely been commenced at the time of inspection.

## Innovation, improvement and sustainability

- The division leads told us of development plans relating to clinic utilisation, equipment replacement and extended clinic hours and had an action plan in place on how this could be managed. This included the identification of additional resources within estates and personnel which would affect the treatment and management of patient care throughout the services. The clinical leads had promoted the development of staff internally to meet demands of increased speciality services (such as sonography) and as a result had fully established teams that shared competence.
- The division was proactive in training staff to meet the demands of the service, developing additional skills that would benefit patient flow through the trust. This included changes within the laboratories, clinics and diagnostic departments.
- The planned repatriation of services was widely discussed by all staff. The additional training and support mechanisms developed to enable the repatriation created an enthusiastic workforce, who assisted with identifying other areas that could be provided by the organisation. We were told that the trust was an interesting place to work as it enabled research and development and exposed staff to a variety of illnesses and diseases due to the local population and proximity to an airport.
- The orthopaedic clinical lead told us of the work currently being completed to redesign patient pathways through the outpatient clinics. The system (called DASH: dependable agile software for healthcare) consisted of an electronic App, which would be used by hand held devices by clinicians. The system will allow patients to be added to waiting lists at each section of their pathway through the department. The pathway experienced would depend on the illness or injury and be pre-planned according to the referral. Each clinician would notify the next section of pathway by notifying

# Outpatients and diagnostic imaging

that their section was completed. This will enable patients to be placed in waiting lists for the individual clinicians. An example of this process was a patient arriving for an outpatient appointment following a fracture. The system would alert the clinician that the patient had arrived in the department. Following the review, the clinician would tick to state that an x-ray was required and the patient would be added to that person's waiting list. Once the x-ray was completed, the system would alert the clinician of the x-ray so it could be reviewed, and following this another alert to the plaster technicians. This system would enable the removal of paper referrals and ensure that patients were seen within the correct order. We were told that the

system was hoped to be in production within a year, with additional patient pathways being added for other specialities after that. It was planned that the trust would trial this system.

- The clinical leads were proactive in the management of staffing across all departments. The team had identified areas where national shortages were evident and in response commenced training their own staff to ensure that they had provision of the specialist. This was evident in the sonography department where staff were being trained and supported internally. Sonography is a diagnostic imaging technique using ultrasound. It is used to see internal body structures such as tendons, muscles, joints, vessels and internal organs.

# Outstanding practice and areas for improvement

## Outstanding practice

- The ED department had a robust process for managing the access and flow in the department which was a multi-disciplinary approach to patient care and had helped to achieve the four hour target consistently since 2012.
- The dementia nurse specialist for the hospital was licensed to deliver the virtual dementia tour to hospital trust staff. The virtual tour gives staff an experience and insight to what it is like living with dementia. The nurse specialist said this was very popular and gave staff an understanding of people's individual needs.
- We saw strong, committed leadership from senior management within the surgical division. The senior staff were responsive, supportive, accessible and available to support staff on a day to day basis and during challenging situations.
- Implementation of Super Saturday for elective surgery lists helped to reduce waiting lists. Two separate general surgeons were on call to meet patient needs for both upper and lower conditions.
- The hospital had an Endometriosis Regional Centre, which was accredited for advanced endometriosis surgery within the region.
- Paediatric services had developed new models of care for the child in the right place, with the right staff, across tertiary, secondary and primary care boundaries. This included the most chronically unwell children having an open passport to access the right tier of care and prevent unnecessary escalation using urgent GP access, paediatric assessment unit, ambulatory support from the community paediatric nursing team and a seven day rapid response team enabling safe care at home.
- We found there was a real commitment and passion to work as a multidisciplinary team delivering a patient centred and high quality service. Neonates, children and young people were at the centre of the service and the highest quality care was a priority for staff.
- There were a range of examples of how, as an integrated service, children's services were able to meet the complex needs of children and young people. The level of information given to parents was often in depth and at times complex, staff managed to communicate with the parents in a way they could understand.
- The NNU had been at the forefront of introducing new treatments and procedures including nitrous oxide therapy, high frequency ventilation and cooling therapy which had resulted in a significant reduction in its mortality and morbidity. The use of innovative ways of working with almost 24/7 consultant cover due to the introduction of new consultants and meeting European Working Time Directives had led to the team being able to treat more complex babies.
- There was a range of examples of working collaboratively and the service used innovative and efficient ways to deliver more joined-up care to people who used services. We observed the service prided itself on meeting the transitional needs of young people living with chronic conditions or disabilities through engagement with adult and community services to improve transition from children and young people's services to adult services.
- The Outpatients' division had very clear leadership, governance and culture which were used to drive and improve the delivery of quality person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure smooth patient pathway through departments.
- Involvement of clinical staff in the development and design of the orthopaedic hub and breast screening unit have enabled clinical needs to be met and promoted a positive patient experience.
- Joint ward rounds with pharmacy staff and ward based clinicians promoted shared learning promoting an improved patient experience and possibly improved outcome.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital SHOULD take to improve

- Ensure that all staff complete mandatory training in line with trust targets, including conflict resolution training.
- Ensure that all relevant staff have the necessary level of safeguarding training.
- Ensure all staff have had an annual appraisal.
- Ensure that information for people who use this service can obtain information in a variety of languages and signage reflects the diversity of the local community.
- Ensure that all services take part in relevant national audits to allow them to be benchmarked amongst their peers and to drive improvements in a timely way.
- Ensure the High Dependency Unit contributes to the Intensive Care National Audit and Research Centre (ICNARC) database, to allow benchmarking against similar services.
- Ensure the time to initial clinical assessment performance information is monitored to give an effective oversight of performance.
- Ensure that all handover documents are completed within the emergency assessment unit.
- Ensure there are consistent processes to enable patients to self-administer their medicines.
- Ensure that there is a standardised consultant led board rounds implemented within the medicine service.
- Ensure that patients receive the recommended input from therapists.
- Ensure environmental repairs are completed in ward areas and kitchen areas.
- Ensure that defined cleaning schedules and standards are in place for all equipment.
- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Ensure patients have their Venous Thromboembolism (VTE) re-assessment 24 hours after admission.
- Continue to ensure lessons learnt and actions taken from never events, incidents and complaints are shared across all staff groups.
- Review the security systems at maternity ward entrances to further improve the safety of women and their babies on the unit.
- Improve the timing of reporting incidents to the National Reporting and Learning System (NRLS).
- Establish parameters for the gynaecology performance dashboard to enable the service to identify areas of compliance that needed addressing.
- Establish appropriate support is available to parents in the maternity unit following the death of their baby.
- Ensure effective collection and oversight of the end of life care service with regards to rapid discharge performance and preferred place of death for patients'.
- Provide adequate waiting area facilities for patient on beds or trolleys within diagnostic areas.
- Provide appropriate facilities to ensure privacy and dignity is maintained for patients who wear gowns for clinical investigations.
- Review plaster technician facilities to ensure appropriate storage and treatment areas are available across the trust.