Kettering General Hospital NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

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

Following the comprehensive inspection of the trust in October 2016, we rated Kettering General Hospital NHS Foundation Trust as inadequate. We rated two key questions, safe and well led, as inadequate. We rated caring as good and effective and responsive as requires improvement. Due to level of concerns found across a number of services and because the quality of health care provided required significant improvement, we served the trust with a warning notice under Section 29A of the Health and Social Care Act 2008.

On the basis of that inspection, we recommended that the trust be placed into special measures, which was confirmed by NHS Improvement.

This focused inspection took place on 14 and 15 June 2017, when we visited unannounced and inspected those services where significant improvements were required. We also carried out announced visits on 22 and 28 June 2017, to speak with senior leaders of the trust. We inspected part of the urgent and emergency care service, children and young people's service and outpatients. We also looked at the governance and risk management systems across the hospital and at board level. As this was a focused inspection, we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question, or any service, or the trust overall, at this inspection.

We found areas where significant improvements had been made:

- The leaders of the trust and in the core services we visited had made significant progress to improve and address the concerns that we had raised at the last inspection.
- Effective risk management processes were now in place, embedded and monitored in the areas visited.
- Staff at all levels were aware of the concerns raised at the last inspection and were involved in driving improvements to address these concerns.
- There was a clear focus on patient safety, effective risk assessment and management throughout the areas visited, which were owned by all staff.
- Staff felt that communication from the trust wide team down to ward staff had improved.
- Patients' privacy and dignity in the areas we visited was respected at all times.
- Staff showed care and compassion towards patients and their families. Patients told us they had been treated with kindness, dignity, and respect.
- Risk assessments and triage tools were used in the emergency department (ED) for patients with mental health concerns, ensuring they were cared for with the correct level of observation in a safe, risk-assessed area.
- Patients arriving by ambulance or self-presenting to ED reception received a timely initial time to clinical assessment.
- There were clear systems in place to safeguard vulnerable children in the ED. The safeguarding policy now reflected national guidance. Safeguarding level 3 children training figures were now above the trust's target of 90% for both nurses and doctors.
- The paediatric ED was staffed with two registered nurses at all times. One of these would be a registered nurse (child branch), if not, there were processes in place to mitigate the risk to ensure paediatric competent nurses were on duty. The paediatric ED was now kept secure, with staff ID badge 'swipe' access only.
- Staff training in paediatric competencies had significantly improved since the last inspection. Training compliance had improved since the recruitment of a practice development nurse, who was now monitoring compliance and performance in this area.
- 'Black breaches' were now reported formally at the trust board and performance monitored and used to drive improvements. All staff could explain what a 'black breach' was.
- The clinical leadership provided by the paediatric lead nurse had been instrumental in the provision and maintenance of a safe and secure environment for children on Skylark ward.

Summary of findings

- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital. Parents were aware of the children and young people with mental health issues and told us they felt their child was 'safe' on Skylark ward.
- Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions. Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.
- Risk assessments for children and young people with mental health issues had significantly improved as had staff access and uptake of mental health and conflict resolution training.
- Staff were able to demonstrate their competence in caring for children and young people with mental health issues. Care was planned and delivered in line with evidence-based guidance.
- Procedures and guidance available to staff was comprehensive and up-to-date and staff were able to respond appropriately to internal security arrangements that kept children and young people safe.
- There was an effective system for identifying, capturing, and managing risks and issues at team and directorate level. The service risk register reflected the risks associated with the children and the adolescents mental health service (CAMHS) patients and children experiencing self-harm behaviour and was reviewed and updated as required. Nursing audits were monitoring care provided against expected standards.
- There were positive relationships with the CAMHS who were open and responsive to the needs of children with mental health needs on Skylark ward.
- The total number of patients waiting over 52 weeks for their treatment on the admitted and non-admitted referral to treatment (RTT) pathways had improved. This had reduced from 413 to 182 patients waiting.
- Where things had gone wrong, duty of candour was maintained. This was evidenced in the medical notes of patients that we looked at.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust also had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete RTT pathways for high-risk specialties.
- There was oversight on the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.
- Managers in the outpatients' service now had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen.
- This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- The trust had recruited its own team of data validators.
- Effective systems were in place to meet the Fit and Proper Persons requirement.
- Trust ownership of safeguarding risks had improved at ward and departmental level although further work was required to embed practice.
- The trust had implemented an effective screening and review system for patient deaths to comply with the recommendations from the 'National learning from deaths' (March 2017) guidance published by NHS England.

However, we also found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival to the ED from April 2016 to March 2017 and was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.
- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not yet meeting national guidance

Summary of findings

for 95% of patients to be triaged within 15 minutes of arrival to the ED. However, during our inspection, all patients' clinical assessments were carried within 15 minutes.

- The computer system the ED used for triaging patients and capturing data was to be improved, so that the first set of clinical observations could be recorded. This would improve data collection and overall monitoring of this performance measure in the ED.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were inappropriately placed on Skylark ward, as there were no other appropriate placements available in the community. This posed a pressure to staff and patients on the ward. This was reflective of system-wide pressures across the health economy.
- The trust was planning to carry out harm reviews on those patients who had died whilst on a waiting list.
- The number of patients waiting for 31 weeks on an RTT pathway had increased from 9% to 27%. Managers were making plans to address this increase.
- The board assurance framework had not significantly changed since the October 2016 inspection. It remained a complex document that lacked clear links with the corporate risk register. The trust recognised that trust-wide governance was not as effective as it needed to be and that some key information was not getting from ward to board.

We saw an area of outstanding practice:

- The trust's clinical harm review had been recognised as an 'exemplar' process and arranged for the trust's process to be presented at the national elective care conference.

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

- Review processes so that 95% of all patients that self-present and arrive by ambulance to the emergency department (ED) receive an initial clinical assessment within 15 minutes.
- Review the current IT system for recording the patient's initial time to clinical assessment, to enable accurate data collection for auditing in the ED.
- Review the trust arrangements with children and adolescents mental health services (CAMHS) and the local clinical commissioning group for the care of CAMHS patients and those patients with self-harming behaviours who are admitted to Skylark ward as a place of safety.
- Continue to monitor the security arrangements on Skylark ward to stop visiting staff allowing other people to follow them into and out of the ward without challenging them.
- Review plans to carry out harm reviews on those patients who had died whilst on a waiting list.
- Develop effective plans to seek to address the increase in the number of patients waiting on RTT pathways for over 31 weeks (which had increased from 9% to 27% at the time of the inspection).

Given the significant improvements found on this inspection, the trust has met the requirements of the Section 29A warning notice that we issued following our last inspection.

The trust remains in special measures and we will continue to monitor the overall improvements being made and by carrying out another comprehensive inspection in due course.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to Kettering General Hospital NHS Foundation Trust

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

There are approximately 613 inpatient beds and over 3,200 whole time equivalent staff employed. All acute services are provided at Kettering Hospital with outpatients' services also being provided at Nene Park, Corby Diagnostic Centre, and Isebrook Hospital. During this inspection, we did not inspect Nene Park, Corby diagnostic centre and Isebrook outpatients.

In 2015/16, the hospital had an income of £218,907,000, and costs of £232,212,000, meaning it had a deficit of £13,304,000 for the year. The hospital predicted that it would have a deficit of £6,355,000 in 2016/17, which rose to £25,000,000 at the year-end.

This focused inspection took place on 14 and 15 June 2017, when we visited unannounced and inspected those services where significant improvements were needed. We also carried announced visits on 22 and 28 June 2017, to speak with senior leaders of the trust.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included five CQC inspectors and a variety of specialists: consultants and senior nurses from paediatrics, accident and emergency, and NHS trust governance experts.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Kettering General Hospital NHS Foundation Trust and after the unannounced inspection visits, we asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, NHS Improvement, and the local Healthwatch.

We carried out this inspection as part of our programme of re-visiting hospitals where significant improvements were required to be made.

This focused inspection took place on 14 and 15 June 2017. We visited unannounced and inspected parts of the urgent and emergency care service, children and young people's service and outpatients. We also looked at the governance and risk management systems across the hospital and at board level. We also carried announced visits on 22 and 28 June 2017, to speak with senior leaders of the trust.

As we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question, or any service, or the trust overall, at this inspection.

We talked with patients and staff from the emergency department, ward areas and outpatients' departments.

Summary of findings

What people who use the trust's services say

In the CQC inpatient survey 2016 (published May 2017), the trust performed about the same as other trusts for all of the 11 questions. Responses were received from 487 patients at Kettering General Hospital NHS Foundation Trust.

Facts and data about this trust

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

The hospital serves a population of around 320,000.

In 2015/16 the hospital had:

- 84,000 A&E attendances.(19 July 2015 to 10 July 2016)
- 81,837 inpatient admissions.
- 275,600 outpatient appointments.
- 3,711 births.
- 923 referrals to the specialist palliative care team.

The hospital reported there had been 1090 in-hospital deaths between April 2015 and March 2016. This represented 51% of the deaths in their catchment area.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? As we only inspected parts of the five key questions (safe, effective, caring, responsive and well led), we have not rated any key question overall. We found areas where significant improvements had been made: • There was a designated mental health assessment room in the emergency department (ED) that complied with national guidance. • Risk assessments and triage tools were used in the ED for patients with mental health concerns, ensuring they were cared for with the correct level of observation in a safe, risk-assessed area. • Patients arriving by ambulance or self-presenting to ED reception received a timely initial clinical assessment. • There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance. Safeguarding level three children's training figures were now above the trust's target of 90% for both nurses and doctors in the ED. • The paediatric emergency department was staffed with two registered nurses at all times. One of these would be a registered nurse (child branch), if not, there were processes in place to mitigate the risk to ensure paediatric competent nurses were on duty. • The paediatric emergency department was now kept secure, with staff ID badge 'swipe' access only. • Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions. • The installation of CCTV and staff swipe card access to the entrance on Skylark ward enabled the entrance/exit to be monitored 24 hours a day seven days a week. • Policies, protocols and 'lockdown' arrangements enabled staff to respond immediately if a child was found to be missing. All security staff had completed training in the appropriate and safe restraint of children and young people. • Risk assessments for children and young people with mental health issues had significantly improved and were becoming embedded in practice. Processes and audits were in place to monitor this and ensure practice had become embedded in the service.	

- Nurses and assistant practitioners had completed competency based risk assessment training, mental health, and conflict resolution training so had the skills to keep people safe.
- Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.
- Where things had gone wrong, duty of candour was maintained. This was evidenced in the medical notes of patients who had suffered moderate harm as a result of waiting for treatment.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust also had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete referral to treatment (RTT) pathways for high-risk specialties.
- There was oversight on the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.

However, we found areas where the service still needed to make improvements:

- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not meeting national guidance which states 95% of patients should be triaged within 15 minutes of arrival to the department. However, during our inspection, all patients had initial clinical assessment within 15 minutes.
- The computer system the ED used for triaging patients and capturing data was to be improved, so that the first set of clinical observations could be recorded. This would improve their data collection and overall monitoring of this performance measure in the ED.
- There were 'blind spots' in the CCTV coverage on Skylark ward. The trust took immediate action to address this once we had raised it as a concern.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff allowing other people to follow them into and out of the ward unchallenged. The trust took immediate action to address this once we had raised it as a concern.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were sometimes inappropriately placed on Skylark ward, as there were no other

appropriate placements available in the community. This posed a pressure to staff and for care of patients on the ward. This was reflective of system-wide pressures across the health economy.
- The trust was planning to carry out harm reviews on those patients who had died whilst on a waiting list.

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). 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 we spoke with were aware of the Duty of Candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. Staff knew the threshold for triggering Duty of Candour was when moderate harm had been experienced. This was in line with the trust policy.
- We reviewed the medical notes of two patients who had suffered moderate harm while waiting for their treatment and saw that clinical staff had written to them to patients offering an apology. Where a serious incidents had occurred, we saw written evidence from the trust to the relevant person in correspondence containing information that had been discussed.
- We requested evidence of harm review process for patients who had died whilst on the waiting list. The trust said the clinical harm review (CHR) and governance process was intended to include patients who had died whilst awaiting treatment but they were conducting CHRs on patients who had waiting over 46 weeks before receiving treatment. The trust was not able to provide evidence of CHRs for patients who had died whilst waiting and senior managers stated they would be reliant on GPs informing the trust of deaths of patients who were on a waiting list. The trust had not been informed of any such cases.

Safeguarding

- During our previous inspection, we found safeguarding procedures did not allow full oversight at board level of potential risks to patients. During the focused inspection, a robust reporting system was in place and processes had been developed to support safeguarding incidents to be tracked. Action plans to address risks were identified by the corporate

business unit (CBU) or ward and were reviewed by the safeguarding lead nurse. The safeguarding steering group oversaw all safeguarding concerns, and developments supported learning from board to ward level.

- However, two safeguarding issues were brought to our attention neither incident was allocated in a timely manner for investigation. The trust had recognised that there were capacity issues in the safeguarding team and at the time of the inspection were recruiting to an additional post in the team. Senior managers were actively monitoring the safeguarding function of the trust to ensure appropriate actions arising from concerns were taken in a timely manner.
- There was evidence of learning and actions shared with staff within both safeguarding incidents, although recording was inconsistent. Following one incident, learning was recorded in team briefing minutes, ward handover sheets and a resource file. Nursing staff we interviewed told us of the incident and of immediate learning and actions taken.
- In the second incident senior ward staff told us of learning and immediate actions taken. However, not all staff were aware of the incident at the time of the inspection. We were not assured action to mitigate the risks had been recorded robustly at ward level or actioned in a timely way to reduce any immediate likelihood of reoccurrence.
- In response to concerns found during our previous inspection, there was progress in the updating of the trust's safeguarding policies and procedures. Trust ownership of safeguarding risks had improved at ward and departmental level although further work was required to embed practice.
- A dashboard was consistently used to record and update progress against action plans and supported themes and patterns of safeguarding concerns to be highlighted. Key performance indicators (KPI's) had been introduced regarding safeguarding patterns to reduce harm. One KPI at the time of inspection concerned failed discharges and progress was seen following the introduction of discharge planning meetings.
- Incidents related to primary care were discussed with the trust's community partners and actions to address gaps identified. For example, workshops with staff were planned to commence in July to share learning and improve communication between wards and discharge lounge staff. Posters were on display to prompt staff to communicate with district nurses before a patient's discharge.
- Since the previous inspection lead nurses within medicine attended a 'huddle' each morning to review progress against safeguarding actions to support key learning being shared. The

matron's forum was also changed to provide practice development in half of the meeting. Ward staff attended the forum to present pressure ulcer incidents to promote a culture of learning and ownership.

- During this inspection, we viewed the ED staff's level three safeguarding children's training figures and spoke with the nursing and clinical leads for the ED. We found there was significant improvement in safeguarding understanding and also in training compliance since the last inspection. The ED had completed the required actions to address the concerns we had raised. There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance.
- Training figures for level three safeguarding children from November 2016 to May 2017 for nursing staff showed 92% compliance and medical staff were 93% compliant, which was better than the trust's target of 90%.
- We checked records for 10 patients and found safeguarding referrals carried out as stated in the trust policy. There was a specific page dedicated to safeguarding in the patients records and on the trust IT system. However, staff told us sometimes there were delays out of hours in getting a social worker to reply to an urgent referral. Staff reviewed all new attendances by children to the ED within 24 hours and informed the relevant authorities and GPs when required.

Incidents

- We did not inspect this element.

Environment and equipment

- At the last inspection in October 2016, the ED had no designated room for patients presenting with mental health conditions in line with Royal College of Emergency Medicine (RCEM) guidelines. The mental health risk assessment tool in use at the time of our inspection did not take into account all environmental and physical risks.
- On this inspection, we reviewed the ED's mental health assessment room. We found it to be compliant with national guidance. Senior leaders in ED had worked in partnership with another local NHS trust to develop the correct assessment tools and the redesign of the room. The clinical lead from the Royal College of Psychiatrists had also visited to risk assess the room and found it met all national standards.
- The mental health assessment room in the ED was still on the service's risk register as a moderate risk. Further work was needed so that the panic alarm button would be made flush

with the wall. However, a risk assessment was in place for this specific risk and the button would break off the wall if anything over 10 kilograms was hung from it. Therefore, the ligature risk was minimal whilst they were waiting for new flush panic alarms. Staff told us that no patients would be left alone, unattended in this room.

- We visited the mental health assessment room at different times of the day and on three separate days during the inspection. During each 'spot check', we found it to be used as documented in their mental health assessment tool and risk assessment, which included an environment hazard check. It was not used as an extra capacity room when the department was busy and was specifically for assessment of patients presenting with mental health concerns. The design, maintenance, and use of facilities and premises met patients' needs.
- We found during this inspection that the ED had made significant improvements to address the concerns we had found on the last inspection. The paediatric ED was only accessible with a trust staff identity swipe card. We found the paediatric ED was secure at all times in our inspection.
- At our October 2016 inspection, we found that some environmental aspects of the paediatric ward (Skylark) were unsafe and not monitored or managed. We also found that Skylark ward was not adequately secure to ensure unauthorised people did not enter the ward and that people could leave the ward unknown to staff. There were no arrangements in place to minimise the risk of a baby or child abduction or children/young people absconding from the department.
- Skylark ward was on level two of the main hospital site. Outside the ward was a balcony, which overlooked the ground floor. This presented a risk to patients admitted to the ward with mental health concerns who may abscond from Skylark ward. We raised concerns about the potential risks the balcony presented and also raised our concerns regarding the entrance and exit of the ward with the trust who took prompt action. Action taken included installing a buzzer entry and exit system as well as CCTV. A security guard was also placed outside the ward 24 hours per day, seven days per week until staff only card swipe access was installed. The trust also revised policies and procedures regarding the potential of a child going missing, enhanced staff training in this area as well as undertaking urgent environmental risk assessments. Actions taken also

included introducing a new risk assessment to ensure the level of care required by patients was assessed on admission: this was developed in conjunction with the Child and Adolescent Mental Health Service (CAMHS).

- During this inspection, we reviewed information as to how the safety of all patients being cared for on Skylark ward was being ensured until the environmental concerns regarding the entry and exit door system and the adjacent balcony had been addressed. Comprehensive risk assessments and associated risk management plans were in place for all CAMHS patients and children at risk of self-harm behaviour. This demonstrated staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions.
- Entry and exit from the ward was managed by staff using an intercom at the nurse's station and was supported by security cameras to enable person's not carrying a swipe card to enter the ward. The system reduced the risk of any child or young person absconding from the ward.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff throughout the inspection allowing other people to follow them into and out of the ward unchallenged. We also observed visitors were able to enter the ward by tailgating through the double doors, once the original requesting visitor had entered the department. The doors remained open for a period of 10-15 seconds. This had been risk assessed in October 2016 and the original time of 20 seconds reduced to fifteen seconds. We noted during our focused inspection there were "blind spots" in the CCTV coverage on the Skylark ward main corridor, which led to the ward. This could enable people to enter the ward unseen. We raised our concerns with the trust regarding entry to the ward at the time of the inspection. The trust placed additional information on the outside of the double doors advising staff and visitors of the safeguarding risks posed to children and young people around tailgating and unauthorised entry to the ward. We advised the security manager during the focused inspection of the "blind spots" in the main corridor and he took action to address them. The security manager was involved in briefing trust staff through staff induction and mandatory training to support the ongoing development of a safety culture across the trust.
- The lead nurse advised us that the long-term plans regarding environmental changes to the balcony outside the exit to the ward were no longer required. This followed the enhanced assessment and management of CAMHS patients and children

at risk of self-harm behaviour. This was supported through increased monitoring of the ward exit and installation of CCTV and swipe cards. Assessments undertaken in October 2016 by the trusts health and safety and estates departments were recorded on the clinical business unit (CBU) risk register in October 2016. The Health and Safety Executive reported in January 2017 that it was confident that the balcony complied with building regulations and did not need to be reassessed. A review of the initial risk assessment was undertaken in December 2016 and the risk score was reduced following the implementation of the controls that were put in place. The risk assessment was reviewed and the risk scores were reviewed again in April 2017 and May 2017.

Assessing and responding to patient risk

Mental health assessment room in ED

- During our inspection, we reviewed the mental health assessment tool and spoke with staff. Patients who presented with a mental health concern were triaged using the newly developed mental health risk assessment triage tool. This determined what level of observation was required and the actions to follow. It also included an environment checklist tool and what steps to take if the mental health assessment room was in use to keep the patient safe until it was available.
- We looked at 10 patient records who presented with a mental health concern and all 10 patients had a fully completed triage assessment. The actions were followed and documented. Training in the use of the mental health triage assessment tool had been carried out with all staff.

Initial time to clinical assessment for ambulance handovers in the emergency department

- The Department of Health recommends that ambulance handovers be completed within 15 minutes of arrival at the ED. In our October 2016 inspection, we found that from April 2016 to September 2016, there were 2,202 handovers of over 30 mins and 323 'black breaches'. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust had reported 'nil' black breaches in the 12 months August 2015 to July 2016 as it had not understood the definition of a 'black breach'.
- On this inspection, all 'black breaches' were now formally reported to the trust board and all staff were aware of the

definition of a 'black breach'. We saw that there were posters in the department saying how many 'black breaches' they had for the month. For May 2017, there had been 75, which was lower than the previous month.

- We looked at five sets of records for patients that had been recorded as a' black breach'. These patients had not been formally handed over to the ED staff, as were still on an ambulance trolley with the ambulance crew. We saw that each patient had had a set of initial observations, or that a nurse/ doctor had seen them whilst they were waiting to be handed over to the ED staff. This assured us that patients, even though waiting 60 minutes or over to be handed over, were still safe whilst they were waiting and their needs were being met.
- The ED had implemented a revised ambulance streaming operating procedure, with a clear pathway for ambulance arrivals and now had an ambulance streaming assessment area of four trolley bays. This had increased from the three trolley spaces at the last inspection.
- During the days of our inspection, all patients that arrived by ambulance were able to be handed over to ED staff and have an initial clinical assessment performed within 15 minutes. We visited the ED unannounced from 9pm to 10.30pm one night and found that there were two ambulance crews waiting to handover their patients into the ED streaming area and these patients had been assessed by one of the senior nurses working in the ED streaming area. They had been assessed as safe to wait until a trolley in ED was free.
- In March 2017, the trust's 'Urgent Care Escalation Meeting' minutes reported that the ED was now the 11th best performing trust in the East Midlands region for the proportion of patient handovers in 15 minutes or less. The average time to clinical handover was 21 minutes. This was an improvement from the last inspection.
- The ED was now capturing the initial time to clinical assessment formally for ambulance arrivals. However due to the limitations of the IT system used, it currently did not enable the clinician to always put the 'real time' on electronic records for when the clinical handover took place. This was something the trust had actioned and had ordered and upgrade on the IT system. Until this IT upgrade was completed, staff completing the clinical handover had to ensure they documented this time manually in the patient records.
- During our evening unannounced visit, we saw that all patients were kept safe from avoidable harm whilst waiting for clinical handover. Staff in the ED had made significant changes in how they worked to become more efficient and make sure their

ambulance patients were handed over and assessed within 15 minutes. This was evident in the gradual improvement of audit results. However, they only achieved this initial time to clinical assessment in 64% of patients in May 2017. Work was ongoing to improve this further.

Initial time to clinical assessment for self-presenting patients in the emergency department

- At our October 2016 inspection, we found concerns about the ED's initial rapid triage system.
- We found during this inspection that the oversight and effectiveness of the streaming system of self-presenting patients had significantly improved. The nurse in charge checked all paediatric patients that booked in and were receiving a timely clinical assessment. This monitoring was also included in the two hourly safety rounds where the nurse in charge would check progress and discuss any possible concerns with the triage nurse.
- ED staff had had training on a nationally recognised triage system. The triage and patient observations process carried out in ED met the recommendations of the 'Initial Assessment of Emergency Department Patients (February 2017)' from RCEM.
- Out of 63 nursing staff, 28 had completed the training and 17 were booked onto the course from June 2017 to August 2017. The percentage of nurses who would be able to triage effectively at the end of August 2017 would be 96%. During our unannounced inspection in the evening, all triage nurses we spoke with had completed the triage system training. From a review of staff rotas, there was a triage-trained nurse on each shift in the past month.
- The ED had two health care assistants who were in two designated triage rooms. These rooms had observation machines that record the patients' blood pressure, heart rate, and oxygen saturations. There were also thermometers and electrocardiogram (ECG, which is heart trace machine) machines. Once the patient had booked in with the receptionist, they would then see the triage nurse, who was triage trained. Staff would then record on the IT system that the patient needed observations and any other tests, such as, an ECG, urine sample, blood test or an intravenous cannula. This was then sent electronically to the health care assistant's (HCAs) computer in the triage room. The HCA would then call the patient straight through into the room and complete the observations and any other initial tests. They then recorded on

the computer to say that this had been completed and this record captured the initial time to clinical assessment. This provided improved accuracy of capturing the correct times that clinical assessments were being done.

Patients waiting on a referral to treatment pathway

- During our last inspection in October 2016, we found there was a system in place to monitor and manage the risk to patients on the waiting list. We saw that the hospital had ceased reporting the Referral to Treatment Time (RTT) in November 2015 due to the hospital data quality concerns. Figures provided by the trust during this inspection showed that the total number of patients on both the admitted and non-admitted pathways waiting over 52 weeks had dropped from 413 to 178 patients. This was an improvement.
- The trust had implemented a 'Clinical Harm Process and Governance process for Patients experiencing delay in treatment on the 18 week RTT pathway' at the start of July 2016. This process reflected agreed amendments from the external RTT assurance group meeting held in May 2016, where NHS England, NHS Improvement (NHSI) and the clinical commissioning group were present. Feedback from NHSI's Intensive Support Team had also been reflected in this policy.
- We looked at 20 records of patients and saw that clinical harm reviews had been carried out on all patients. The medical director and a clinical harm coordinator oversaw the reviews. Patient medical notes were sent to relevant consultants who were required to ensure that patient reviews were conducted. Patients who were found to have been caused potential harm as a result of any delays in treatment were identified. The outcomes of this process were included in the reports to the external RTT assurance group and the trust's board.
- Information provided by the trust showed that as of 12 July 2017, 1,709 patients had waited over 52 weeks for an appointment (both non-admitted and admitted RTT pathways) and 1,281 patients had had a CHR carried out. Of these, 1,137 had suffered no harm and 133 had suffered low harm. Of the 437 CHRs not yet completed: this was due to staff awaiting patient notes in 292 cases and we saw that 113 CHRs were in progress.
- For the completed CHRs, 89% showed no harm had been experienced, 10% showed low harm and 0.2% showed moderate harm.
- All low and moderate harms cases identified were reviewed by the trust's medical director and any contentious issues were taken to expert panel of senior clinicians for review. We also saw

that a sample of no harm cases were reviewed on a weekly basis for quality assurance purposes and that low harm cases from two GP practices were sent to primary care physicians to conduct a clinical review on the patients' primary care record.

- The trust had an 'Elective care access policy', which had been reviewed and ratified by the trust's management committee on 25 April 2017. This policy gave guidance for the safety and prioritisation of patients on the RTT waiting list and which stated that where patients had waited over 35 weeks, they would become a higher priority and treated as soon as possible. Where a patient had waited longer than 35 weeks on the RTT pathway, the policy stated that when booking outpatient appointments, patients who were on a two-week wait pathway would be prioritised, followed by urgent appointments and higher priority cases as agreed by the clinical teams.
- The hospital relied on patients to contact their GP in case of any concerns. The trust had written to all primary care providers to make them aware of the RTT position and requested that if any GP had concerns about a particular patient they should bring it to the attention of the relevant consultant. A range of information had been sent to all local GPs, and the trust had also raised the waiting list issue in the local media and on their public website, to raise public awareness of the delays in receiving treatment for patients on RTT pathways.

Staffing

- The ED had a staffing increase so senior managers were now able to recruit more registered nurses (children branch) as the staffing establishment had been increased. This was an extra four whole time equivalent nursing staff posts. A registered nurse (children's branch) is a registered nurse who has specific training and competencies to be able to assess and care for children. The trust also appointed a matron for children's ED in November 2016.
- The paediatric ED was now staffed with two registered nurses, one of which was a paediatric-trained nurse. This was significant improvement from the one registered nurse and one health care assistant in place on the staffing rota at the last inspection
- On all shifts during our inspection, there were two registered nurses in the paediatric department and one was always a registered paediatric nurse (child branch). We found this to be the case during our unannounced evening inspection and we also looked at the paediatric ED staffing rota records for the month prior to our inspection and we saw from 15 May to the

11 June 2017, that eight out of 56 shifts were not covered by a registered nurse (child branch). There was evidence on these shifts that the registered nurses on duty in the paediatric ED received paediatric competencies and PILS training which was in line with the Royal College of Paediatrics and Child Health 'Standards for Children and Young People in Emergency Care Settings' (2012) guidance.

- The staffing levels in the paediatric ED was included in the nurse in charge's two hourly safety rounds. If there was a paediatric emergency in the resuscitation room, then a registered nurse (child branch) would attend from the hospital's paediatric ward.

Are services at this trust effective?

As we only inspected parts of the five key questions (safe, effective, caring, responsive and well led), we have not rated any key question overall.

We found areas where significant improvements had been made:

- Staff training in paediatric competencies in the emergency department (ED) had significantly improved since the last inspection.
- Training compliance in ED had improved since the recruitment of a practice development nurse, who was monitoring compliance and performance in this area.

Competent staff

- There was a paediatric competency framework for adult nurses working in the children's ED. However, at the time of our last inspection, the paediatric competency framework for adult nurses was not being monitored by senior staff for adult trained staff working in the the children's ED. We found that there were 23 registered nurses who still required paediatric competency training.
- At this inspection, we found that 13 adult trained nurses were now signed off on these paediatric competencies. The remaining 10 staff were in the process of completing them and were on trajectory to have these complete by the end of June 2017.
- We saw an ED training action plan, which had been developed by the ED practice development nurse. This nurse was responsible for training the nurses in ED in the paediatric competencies. This was a new post for the ED and significant improvements in this area had been made since the last

inspection. The ED practice development nurse was checking and monitoring the paediatric competency framework and staffs' compliance with this on an ongoing basis to fully embed this action.

Evidence based care and treatment

- We did not inspect this element.

Patient outcomes

- We did not inspect this element.

Multidisciplinary working

- We did not inspect this element.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We did not inspect this element.

Are services at this trust caring?

As we only inspected parts of the five key questions (safe, effective, caring, responsive and well led), we have not rated any key question overall.

We found that:

- Staff showed care and compassion towards patients and their families.
- Patients told us they had been treated with kindness, dignity, and respect.
- Privacy and dignity was respected at all times whilst patients were being cared for within the main emergency department (ED) by the nurses and doctors.
- All interactions we observed between staff, children and young people, and their carers, were caring, compassionate, respectful, and friendly on Skylark ward. Parents were aware that some children and young people with mental health issues were being cared for on the ward at times and told us they felt their child was well cared for by the staff and 'safe' on Skylark ward.

Compassionate care

- We spoke with 10 patients who were very happy with the care they received in the ED. Patients who had visited the department in previous months told us they were seen much quicker this time than previously.
- Staff showed compassion during all times of clinical assessment and treatment.

- Patients told us they had been treated with kindness, dignity, and respect.
- We observed staff introducing themselves to patients and relatives. Staff would ask the patient how they would like to be addressed. All interactions were observed to be caring and respectful.
- Privacy and dignity was maintained during all interactions and assessment with patients in all clinical areas. Staff we observed showed an awareness of respecting their patient's privacy and dignity by closing curtains around all bays in the ED.
- We found that some patients' privacy could not always be maintained when patients were booking into the ED at reception due to the layout of this area, but staff took all appropriate actions they could to address this.
- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital.
- All interactions we observed between staff, children and young people and their carers, were caring, compassionate, respectful, and friendly on Skylark ward.
- Nurses, consultants, and support staff were friendly and welcoming to children and their families and were skilled in communicating with children and young people. Children and their relatives told us how happy they were with the care throughout the hospital. They said staff were very caring, one relative said "they always felt fully informed".
- In outpatient areas visited, staff were kind and caring in all interactions with patients observed. Patients' privacy and dignity was respected by staff in the areas we visited.

Understanding and involvement of patients and those close to them

- The patients we spoke with told us that they were involved and regularly updated with their treatment plan and potential diagnosis. They felt able to discuss any queries or concerns with the nurse and doctor involved in their care.
- Relatives were made to feel welcome and sit with patients. This would be after the staff had gained consent from the patient.
- We saw doctors speaking with the patient and their carers together, keeping them involved and up to date with their plan of care.
- Children and their parents felt well informed about their care and treatment.

- Parents and children said ward staff went out of their way to include them in the planning and delivery of their care. We observed how staff explained things to the parent and child. For example, we saw a nurse explain a procedure to a child. We saw how this reassured the child and the parent.
- Parents told us they were given sufficient advice following their child's discharge from hospital and knew whom to contact if their child became unwell. Parents understood when they would need to attend the hospital for repeat investigations or when to expect a follow-up outpatient appointment.

Emotional support

- We did not inspect this element.

Are services at this trust responsive?

As we only inspected parts of the five key questions (safe, effective, caring, responsive and well led), we have not rated any key question overall.

We found that:

- Arrangements with the children and adolescents mental health service (CAMHS) were responsive to the needs of children and young people with mental health issues.
- The trust's Referral to Treatment (RTT) performance had improved from 69% (based on unvalidated data) in October 2016 to 75% in June 2017.
- The hospital was performing better than the national operational standards for all types of cancer referrals.
- There were 178 patients (for both admitted and non-admitted RTT pathways) waiting over 52 weeks. This was an improvement from the last inspection.
- The trust had returned to national reporting of RTTs from March 2017 following support from NHS Improvement.
- 'RTT Confirm and Challenge' meetings regarding RTT performance were being held every two weeks. Information from April to June 2017 showed clear actions by speciality, current RTT performance, additional resource updates, and harm reviews learning that had been implemented.
- An elective care e-learning programme to help teams reduce waiting times and improve access was launched by the trust in June 2017 and 93% of eligible staff had received this training.
- Additional weekend lists at the hospital and the use of private providers were used to reduce patient waiting times.
- Referrals to for outpatient appointments were prioritised by clinical urgency.

However, we also found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival to the ED between April 2016 and March 2017. This was below the England average for all of the 12 months.
- Overall, for that period, the emergency department achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were sometimes inappropriately placed on Skylark ward, as there were no other appropriate placements available in the community. This posed a pressure to staff and for care of patients on the ward. This was reflective of system-wide pressures across the health economy.
- Delayed discharges on Skylark ward were reflective of system wide pressures in the local health economy.
- The number of patients on an RTT pathway waiting for 31 weeks had increased from 9% to 27%. Managers were making plans to address this increase.

Service planning and delivery to meet the needs of local people

- We did not inspect this element.

Meeting people's individual needs

- We did not inspect this element.

Dementia

- We did not inspect this element.

Access and flow

- The Department of Health's standard for emergency departments (ED) states 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. The hospital failed to meet this target from April 2016 to March 2017 and was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, and the trend over time was showing improvements in meeting this performance measure. In March 2017, there had been 7,652 attendances to the ED (an average of 246 each day).
- Performance against the four-hour indicator was a part of the overall urgent care overall improvement plan. This was discussed at board level. It was recognised that performance against this target was affected by other factors in the trust and

the wider care network, such as delayed transfers of care and patients that were medically fit for discharge in inpatient areas whilst they waited for appropriate care to be arranged in the community.

- The ED had a recovery plan to improve performance to four-hour performance measure. This had been agreed with local commissioners and other stakeholders. From April 2016 to December 2016, the ED met and exceeded their planned trajectory for improvement in four-hour performance.
- During our inspection, the average time to initial clinical assessment for patients was better than 15 minutes (which is the national standard). For the period April 2016 to March 2017, the average time to initial clinical assessment for all patients reported nationally by the trust was 13 minutes. This met the national standard, but was worse than the England average of seven minutes for this period.
  - For the period April 2016 to March 2017, the average time from arrival to treatment reported by the trust was 59 minutes. This met the national standard of 60 minutes. This was also in line with the England average of 60 minutes for this period.
  - From April 2016 to March 2017, the number of patients waiting between four and 12 hours to be admitted to an inpatient bed was worse than the England average at 24% whilst the England average was 13% for this period
  - Admission rates from ED to inpatient wards had shown an increase from 25% in the year 2015 to 2016 to 32% in the last year (2016 to 2017). Staff said this reflected more people attending the ED needed admission to inpatient beds due to their condition and acuity.
  - From April 2016 to March 2017, the median total time spent in the ED was 158 minutes, slightly longer than the England average of 148 minutes for this period.
  - When a decision was made to admit a patient to a hospital ward, no patients waited more than 12 hours in the ED for a bed between January and March 2017.
- During our inspection, we identified that in May 2017 there were 44 admissions of children and young people with deliberate self-harm behaviour to Skylark ward. This was double the usual admission rate of around 23 a month. This was the highest number of admissions experienced by Skylark ward for this care group. System-wide children and adolescents mental health service (CAMHS) pressures were escalating throughout Northamptonshire.

Summary of findings

- Of all the children and young people assessed by CAMHS in May, two required a specialist mental health bed. In the same period, three children and young people waited on the ward for up to seven days due to a lack of specialist social care placements in Northamptonshire.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter.
- At our last inspection, the trust senior managers told us that the hospital was not reporting RTT performance for incomplete pathways at the time of inspection due to historical problems with their data that occurred following an IT system upgrade in August 2015. They had not reported RTT performance nationally since November 2015. The trust was in the process of validating over 150,000 data entries on the patient-tracking list to ensure they were accurately recording and managing waiting times. Figures from October 2016 (based on unvalidated data) showed that 69% of patients were being seen within 18 weeks. This was below the national standard of 92%.
- The trust had returned to national reporting of its RTT figures at the end of March 2017 following significant support from NHS Improvement's Intensive Support team. 'RTT Confirm and Challenge' meetings regarding RTT performance were held every two weeks. Data from April 2017 to June 2017 showed clear actions by speciality, current RTT performance, additional resource updates, and harm reviews' learning being implemented.
- During this inspection, from nationally reported data for May 2017, the trust's overall performance for RTT waiting times was 74%, with half of patients waiting less than 10 weeks and 92% of patients waiting less than 32 weeks.
  - As of 20 June 2017, 5,702 patients waiting more than 18 weeks, which indicated the trust was achieving performance of 75%. This was marginally below the trust's trajectory for improvement target, which was 77%.
  - The trust was on track to achieve the trajectory target by the end of August 2017, which had been agreed with local clinical commissioning group.

  - There were 178 patients (for both admitted and non-admitted RTT pathways) waiting over 52 weeks. This again was an improvement from the last inspection.
  - For non-admitted RTT pathways, there were 751 patients waiting over 31 weeks (4.1%) and 28 patients waiting more than 52 weeks (0.2%)
  - For admitted RTT pathways, there were 1,059 patients waiting more than 31 weeks (22.9%) and 150 waiting more than 52 weeks (3.2%)
- We saw that the patient record data validation programme had been completed for all patients waiting over 52 weeks as of 20 April 2017.
- Whilst the trust was working towards meeting their trajectory to have no patients waiting over 52 weeks by Autumn 2017, figures reviewed at the time of our inspection showed an increase in number of patients waiting 31 weeks or more from 9% to 27%. In addition, there was an increase in number of patients waiting for 40 weeks of more from 4% to 13%. Senior managers were aware of this rise and were taking actions to deal with this increase via the 'RTT Confirm and Challenge' meetings, where performance was reviewed and the actions agreed to continue to improve performance. This included the use of an external organisation to undertake some appointments and treatments required as well as weekend clinics in some specialties.
- Referrals were prioritised by clinical urgency: suspected cancer referrals first, then urgent referrals and then routine referrals on a 'next in turn' basis. Suspected cancer and urgent referrals did not experience any delays in accessing appointments. The maximum waiting time for suspected cancer referrals is two weeks from the day a patient's appointment is booked through the NHS e-referral service,or when the hospital or service receives the referral letter.
- Nationally reported data for May 2017 showed the service was performing better than the national operational standards for all types of cancer referrals.
- During our inspection in October 2016, we saw that the outpatients' department did not always have the capacity to run additional clinics to meet the demands of the service. This had improved since March 2017. The hospital's action plan for reducing their waiting lists included running additional clinics and in sourcing a private provider to run additional clinics to meet the demand for outpatient services. The private provider ran additional weekend clinics to bring down the ophthalmology, general surgery, and urology waiting lists, and the length of time patients had to wait. The private provider ran 634 additional clinics by the time of our inspection.

Summary of findings

Learning from complaints and concerns

- We did not inspect this element.

Are services at this trust well-led?

As we only inspected parts of the five key questions (safe, effective, caring, responsive and well led), we have not rated any key question overall.

We found areas where significant improvements had been made:

- The leaders of the trust had made significant progress to improve and address the concerns that we had raised at the last inspection.
- Effective risk management processes were now in place in the areas we visited. These were embedded and monitored. Further work was being carried out to review all risks on the corporate risk register in detail.
- Staff at all levels were aware of the concerns raised at the last inspection and were involved in driving improvements to address these concerns.
- There was a clear focus on patient safety, effective risk assessment and management throughout the areas visited. This was owned by all staff.
- Governance systems in place had significantly improved so that staff, at all levels, from ward to board, understood the areas of risk within the service. We saw that a series of actions had been implemented and embedded in the services to minimise risk to patients.
- Staff felt that communication from the trust wide team down to ward staff had improved.
- 'Black breaches' were now reported formally at the trust board and performance monitored and used to drive improvements. All staff could explain what a 'black breach' was.
- The clinical business unit risk registers reflected the risks in the services.
- Managers in the trust now had an effective oversight of the hospital's referral to treatment (RTT) performance and could clearly show how the recording system worked and the number of patients waiting to be seen.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- Effective systems were in place to meet the Fit and Proper Persons requirement.

- Trust ownership of safeguarding risks had improved at ward and departmental level although further work was required to embed practice.
- The trust had implemented an effective screening and review system for patient deaths to comply with the recommendations from the 'National learning from deaths' (March 2017) guidance from NHS England.

However, we found also found that:

- The board assurance framework had not significantly changed since the October 2016 inspection. It remained a complex document lacking clear links with the corporate risk register. The trust recognised that trust-wide governance was not as effective as it needed to be and that some key information was not getting from ward to board.

Leadership of the trust

- Since our last inspection, there had been one change in the executive directors in March 2017, when a new interim chief executive officer (CEO) had joined the trust. The trust had not received the support of an improvement director but plans were in place for this to be provided.
- In response to the findings of the previous inspection, the trust had, through NHS Improvement, commissioned a review of trust leadership and governance by an independent provider. This was due to take place in July 2017.
- The new interim CEO, supported by the board, had made a number of changes in the way that the trust's governance systems operated. This had led to an improvement in the recorded challenge from non-executive directors (NEDs) to the trust board. All papers discussed at the board's sub-committees had a greater level of scrutiny recorded and were then presented to the board. We observed a public board meeting prior to the inspection and saw that the level of challenge from the NEDs had improved.
- As part of the longer-term programme to drive improvements in the trust, the CEO and director of human resources were actively using the trust values to underpin all operational and cultural changes. In response to the concerns found at the last inspection, a 'getting the basics' right approach had been adopted as the first part of the longer term plans to improve the quality and safety of services being provided.
- A newly created post of director of integrated governance had just been recruited to: this post was to provide the executive team with capacity to take a firm grip on the improvements required across the trust.

- We saw the deputy chief operating officer visible in the ED. They were discussing the flow through the department with the nurse in charge and the plans for patients who were waiting to be admitted.
- This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings. Clear, ongoing communication with NHS improvement (NHSI) and the local clinical commissioning groups (CCG) was evident.

Vision and strategy

- Staff we spoke to were aware of the trust wide values that underpinned the divisional vision. There were to be 'Compassionate, Accountable, Respectful, and Engaging': the 'CARE' values. The trust was underpinning its programme of transformational change using these values to ensure they were embedded in the all aspects of all services being provided.

Governance, risk management and quality measurement

- At the inspection in October 2016, we found a lack of clear links between the board assurance framework and the corporate risk register, limited consistency in the rating of risk and that not all risks were identified. There lacked clear links between the further control and mitigating action and the wording of the risk description.
- Each clinical business unit reviewed their risk profile monthly and these had been reviewed by the risk management steering group in June 2017. Training on the risk register was booked for board members with a further session for senior managers in August 2017. Some managers including directors had received one to one training with the risk manager.
- Since the last inspection, the trust had appointed a risk manager and had revised its local and corporate risk register function, by using an electronic system to capture all local, clinical business unit risks. All significant risks were then transferred into the corporate risk register. Senior managers said that this was work in progress, and a detailed review of all risks, actions and mitigations was being carried out so that the corporate risk register would present a more structured and current assessment of risks in the trust.
- The board assurance framework had not significantly changed since the October 2016 inspection. It remained a complex document lacking clear links with the corporate risk register.

The trust recognised that trust-wide governance was not as effective as it needed to be and that key information was not getting from ward to board. In May 2017 NHS Improvement had undertaken a governance review of the trust. The findings were similar to the CQC inspection in October 2016. There was recognition from the executive team, supported by the non-executives, that further integration of risk management was required. In order to take governance further forward the trust had appointed a director of integrated governance.

- A quality improvement plan had been developed to address the issues from the last inspection, this was aligned to the trusts' values. The plan clearly detailed the 'must do's', actions required, timescales, if external support was required, progress against the original timescale, monitoring arrangements and executive lead. There were also plans to rate the delivery of the action against a red, amber or green scale this had yet to be completed as the trust saw sustainability as a key to success and it was too soon to be assessing this. The place of this plan within the governance structure was clearly articulated, as was the communication plan for both internal and external stakeholders.
- The clinical business unit (CBU) risk register for ED that was in place at the time of the last inspection did not accurately reflect the risks in the service that we found during the inspection. At this inspection, we found that this had significantly improved. The completion of the ED service's risk assessments was discussed at the risk management steering group meetings and improvement actions were minuted.
- The trust senior leaders were now aware of the level of risk regarding the 'black breaches' and the governance systems in place were sufficient to allow full oversight at board level of the potential risk to patients. Since the last inspection, the leaders in ED and executive team had put systems in place to monitor and formally report to the trust board on 'black breaches'. There was now oversight at board level of the potential risk to patients.
- There were clinical site meetings led by the COO, which were held throughout the day and were increased if the ED was under capacity pressures. The waiting times of ambulances was discussed at these meetings. The ED leadership team, along with the COO and the deputy COO, had worked closely with the leadership team from the local NHS ambulance trust. ED leaders had also made significant improvements to the ED patient triage process were effective.
- During our previous inspection, we found that the risk management processes in place were not sufficient in the

children and young people's service to recognise, assess, monitor, and review and therefore reduce risks. The trust was not aware of the level of risk regarding this concern until we raised this as an urgent concern. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.

- On this inspection, we found that risk management processes that were now in place had significantly improved and were sufficient to recognise, assess, monitor and review and therefore reduce risks. Governance systems in place had significantly improved so that staff, at all levels, from ward to board, understood the areas of risk within the service, and we saw that a series of actions had been implemented and embedded in the service to minimise risk to patients. Staff were able to demonstrate their competence in caring for children and young people with mental health issues due the training delivered as a result of our last inspection.
- Senior staff said the outpatients' service was well represented at board level. The COO was the executive lead for the outpatient quality improvement programme. We saw evidence that regular reviews were held to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department. Clinical staff carried out clinical harm reviews (CHRs) for patients who had been waiting over 52 weeks. Data provided by the trust showed CHRs were carried out in high-risk specialties after 46 weeks. Senior staff we spoke with said there was a weekly report for patients waiting over 46 weeks and for the trust's executive team.
- We saw that the following governance and assurance framework was established in the outpatient service:
  - 'RTT Executive Assurance Group' bi-weekly meetings with the trust, NHS England, NHSI and the local CCGs.
  - Monthly reports to the trust's Board of Directors.
  - Monthly reports to the trust's performance, finance and resources committees.
  - Trust attendance at monthly Progress Review Meetings with NHSI with RTT performance updates provided.
  - Trust attendance at quarterly meetings with NHSI with RTT performance updates provided.
- The outpatients' service held two weekly 'RTT Confirm and Challenge' meetings, chaired by the deputy COO. The meetings were previously called the 'RTT Operational Group Meeting'**.** We reviewed minutes of these meetings held from October 2016 to June 2017. There were no minutes for the meetings held on the 14 November 2016 and 07 February 2017. Senior managers told us this was because these were small group discussion and not

full meetings. We saw there were clear discussions about performance, data validations, actions required to improve performance and clinical harm reviews that had been carried out.

- We reviewed the recent dashboards for the service and this dashboard gave clear information as to the overall RTT performance positions, individual speciality performance, the number of patients on a waiting list and for how long, the number of clinical harm reviews carried out, and those yet to be done (with the rationale as to why there was any delay).
- External validators stopped working in the trust at the start of June 2017, as the trust had appointed its data validation team comprising of one whole time equivalent (WTE) manager, one WTE validation team manager, one WTE data quality and training lead and nine WTE data validators.
- The trust had implemented an effective screening and review system for patient deaths to comply with the recommendations from the 'National learning from deaths' (March 2017) guidance from NHS England and was using the Royal College of Physicians' 'Structured Judgement Review' case note methodology. Other NHS trust's senior staff had visited to observe this process.

Culture within the trust

- Staff in ED said how the culture had significantly improved in the team since the last inspection in October 2016. Staff previously felt that not enough support was given to the ED during times of extreme pressure to maintain access and flow. Staff had felt that it was 'an ED problem', with no real support seen to be given from the trust wide team.
- Staff now felt that managers and leaders were visible and approachable. The communication between the leaders of ED and the executive team had significantly improved. Staff said there were effective communication systems in place to convey important information, such as bed availability and escalation of patient risks in times of high demand and capacity pressures in the ED. Staff said that their ideas were listened to and they were kept involved of the ongoing changes to improve patient safety within the ED.
- Staff we spoke with on Skylark ward said that morale was now improving after the last inspection report was published and that all staff were committed to ensuring the service delivered the best possible care for all patients. Staff said they were well supported by local and senior managers of the trust.

Equalities and Diversity – including Workforce Race Equality Standard

- We did not inspect this element.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a regulation that intends to make sure senior directors are of good character and have the right qualifications and experience to work in this role.
- At our last inspection, there were not effective systems in place to ensure evidence of all required pre-employment checks had been carried out. The trust did not have a policy in place governing this requirement.
- At this inspection a comprehensive mechanisms was in place for the fit and proper person test for newly appointed executives and board members. A clearly defined policy was in place to govern this process.
- A new FFPR policy had been ratified and implemented that reflected all the requirements of the requirement.
- The trust had carried out an audit of all relevant files and processes and we saw that all recommendations from this audit had been carried out.
- We reviewed a sample of four director's (including non-executive directors) files to assess compliance against fit and proper person legislation and found that all the required checks had been carried out. Each file was well maintained and organised with a clear referencing system. The trust planned to carry our regular audits of staff files on a cyclical basis to ensure appropriate documentation was in place. This represented a significant improvement to meet the requirements of the Section 29A Warning Notice and effective governance arrangements for this requirement were now in place.

Public engagement

- We did not inspect this element.

Staff engagement

- We did not inspect this element.

Innovation, improvement and sustainability

- We did not inspect this element.

Outstanding practice and areas for improvement

Outstanding practice

The trust's clinical harm review had been recognised as an 'exemplar' process and arranged for the trust's process to be presented at the national elective care conference.