The Princess Alexandra Hospital NHS Trust

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

Date of inspection visit:
5 December to 19 December 2017

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21 March 2017

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Details of sites and locations registered with CQC and specialist services provided at the trust

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Alexandra Hospital</td>
<td>Hamstel Rd Harlow Essex, CM20 1QX</td>
<td>A&amp;E, Children and Young People, Critical Care, Maternity, Surgery, Medicine and Outpatients</td>
<td>Harlow, West Essex &amp; East Hertfordshire</td>
</tr>
<tr>
<td>Herts &amp; Essex Hospital</td>
<td>Haymeads Lane Bishop’s Stortford Essex CM23 5JH</td>
<td>Outpatients</td>
<td>Harlow, West Essex &amp; East Hertfordshire</td>
</tr>
<tr>
<td>St Margaret's Hospital</td>
<td>The Plain Epping Essex, CM16 6TN</td>
<td>Urology outpatient and day case unit, Outpatient clinics for breast services and Outpatient clinics</td>
<td>Harlow, West Essex &amp; East Hertfordshire</td>
</tr>
</tbody>
</table>

(Source: Trust Website)
Background to the trust

The Princess Alexandra Hospital was built in the mid 1960's, and the building is showing very significant signs of age with a backlog of maintenance estimated to be around £50m, and there is very little room for expansion on the current site.

The Princess Alexandra Hospital NHS Trust was established as an NHS Trust in April 1995. The trust provides a comprehensive range of acute and specialist services. The main site is the Princess Alexandra Hospital, which is a district general hospital. There are also three smaller sites where services are provided. These are:

- Herts and Essex Hospital
- St Margaret’s Hospital

We last inspected the trust in June 2016 as part of our comprehensive inspection programme, where we found there had been some deterioration in the quality of services provided since our previous inspection in 2015.

In June 2016, we rated urgent and emergency services, critical care, and end of life care as inadequate, medical care, surgery and services for children and young people as requires improvement, outpatient and diagnostic imaging as good and maternity and gynaecology as outstanding.

At our inspection in June 2016, we rated safe, responsive and well led as inadequate, effective was rated as requires improvement and caring was rated as good. The trust was rated as inadequate overall due to significant concerns in safety, responsiveness and leadership, with an apparent disconnect between the trust board level and the ward level. Following this inspection, the trust was placed in special measures. This enabled the trust to receive support from the special measures regime and the trust was appointed an NHS Improvement director to work alongside the trust board to support, advise and challenge the outcomes from any actions taken.

During our most recent inspection, we found there had been an improvement in the quality of services provided since our previous inspection in June 2016.

Facts and data about the trust

The trust has 480 acute inpatient beds, 12 critical care beds and 61 maternity beds and employs around 2,846 full time equivalent staff across the four sites. Of these staff, 634 are nurses, 427 are medical staff and 1,785 are classified as other staff.

The hospital is located in Harlow, Essex and provides acute and specialist services to a population of around 350,000 people from the West Essex and Hertfordshire region. within the area of Harlow, Epping, Uttlesford, Bishops Stortford and Loughton. Outlying clinics are based in Bishops Stortford, Loughton and Epping. Harlow is on the border between Essex and Hertfordshire and the Trust is commissioned by two CCG’s, NHS West Essex CCG and NHS East and North Hertfordshire CCG.

Patient numbers

July 2016 to June 2017, the trust saw

- 53,712 inpatient admissions (July 15 to June 16 - 53,389)
- 334,090 outpatient attendances (July 15 to June 16 – 324,506 ),
- 101,155 A&E attendances (July 15 to June 16 – 102,388)
- 3,970 babies born (July 15 to June16 – 3,961)
• 983 hospital deaths (July 15 to June 16 – 989)
• bed days (July 15 to June 16 – 148,014)

Financial positions

The trust’s outturn deficit in 2015/16 was £37.7m. In 2016/17, the trust agreed a control target of £29.7m and participated in NHSI Financial Improvement Programme (FIP Phase 1). It delivered a financial outturn of £26.7m, £3m better than planned. The cost improvement programme (CIP) plan for 2016/17 of £11.5m and was fully delivered. Temporary staffing costs reduced significantly in 2016/17 (2015/16 £30.5m, 2016/17 £24.7m) including agency costs of £15m (2015/16 £20m). The trust’s External Auditors report for 2016/17 recognised ‘significant progress compared to the prior year in controlling costs’.

Despite improvement, the trust's underlying financial deficit remains a significant challenge. The 2017/18 net control target deficit is £21.6m reducing further in 2018/19 to a net of £15.4m. These figures are inclusive of sustainability and transformation funds (STF). The gross control total deficit is £29.1m, before STF of £7.5m. Its agency cost target for 2017/18 is consistent with 2016/17 (£13.7m) but is reduced to £10.3m for 2018/19. For 2017/18, the Trust has a CIP plan of £8m representing 3.6% of its income base.

• Projected surplus £37,714
• Turnover £196,124
• Not in NHSI financial special measures
• Not in single oversight framework segmentation

As part of the trust's strategy to address its aging estate, its clinical sustainability and underlying structural deficit a clearer strategic direction has been developed; this has been recognised by the trust's external auditors. The trust has submitted a Strategic Outline Case to its Regulators for Acute Healthcare Estate Transformation. This is a significant (£540 m) capital proposal to develop an integrated health and wellbeing campus to transform healthcare services and deliver significant efficiencies. The scheme has full support from all Commissioners, local authorities and sustainability and transformation plans (STP).

What people who use the trust's services say

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. The Princess Alexandra NHS Trust scored about the same as the England average for recommending the trust as a place to receive care from October 2016 to September 2017. At the time of our inspection, 96% of patients said they would recommend this hospital, compared to the England average of 96%.
In the CQC adult inpatient survey 2017, the trust performed about the same as other trusts in four of the 11 questions examined by the CQC, and worse than the other trusts in the remaining seven questions. Responses were received from 497 patients, aged 16 or over, who had at least one overnight stay at the Princess Alexandra Hospital NHS Trust.

In the CQC children and young people survey 2016 (patients who received inpatient or day case care during October, November and December 2016). The trust performed about the same for eight of the nine questions examine by CQC, and better than other trusts for information about medicines. Responses were received from 142 patients at the Princess Alexandra Hospital NHS Trust.

In the CQC emergency department survey 2017, people who used emergency department survey. Responses were received from 328 people at the Princess Alexandra Hospital NHS Trust. The trust performed about the same as other trusts in six of the nine questions examined by CQC, and worse than other trusts in the other three questions.

The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2017 in one out of the four domains. It scored the same as the England average for cleanliness slightly worse than the England average for privacy, dignity and wellbeing and food.

Is this organisation well-led?

Leadership
In order to write this well-led report, and rate the organisation, we interviewed the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital. This included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of
the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

The trust board consisted of five voting executive directors, a chairman, six voting non-executive directors (NEDs), and two non-voting associate non-executive directors.

The trust board and senior leadership team had the skills, knowledge, experience and integrity to lead the trust. The trust board members we met had a wide range of experience, knowledge and skills. The Chief Executive Officer (CEO) was an experienced leader who had recent experience of leading a trust in special measures, and had been appointed as CEO in May 2017. The chairman, who had a similar experience in chairing trusts which had been in special measures, had been in post since December 2016. In addition to his role at this trust, the chairman also undertook this role at another NHS trust. The chief medical officer March 2015 and the chief nurse, who was also the deputy CEO, had been in post since 2012. The chief operating officer (COO) had been in post since 2015.

The eight NEDs had joined the trust at differing dates between September 2015 and August 2017. Throughout our well-led inspection, we spoke with five NEDs. Two of the NEDs had a clinical background, one from the nursing profession and the other form the medical profession. We spoke with five NEDs as part of our well-led inspection. From our conversations with them, we were assured they had the skills and relevant experience to undertake their role.

The commitment to developing staff and succession planning was evident through the support of deputy director level staff. The chief medical officer, chief nurse and the COO had deputy staff with the appropriate level of understanding, skills and knowledge to support them as required and in times of absence. In addition, there was a commitment to developing staff at all levels through leadership development programmes. Between April 2016 and March 2017, there had been 575 attendances on core leadership and management programmes. Staff we spoken with at our focus groups told us that they had been supported to undertake leadership programmes. The trust was also supporting junior staff to develop, for example, associate nurses were being supported to undertake their full training to become registered nurses. The trust had also linked in with a local college to support band two staff to undertake a course to enable them to gain essential qualifications in literacy and numeracy.

At our previous inspection in June 2016, we found there was a disconnect between the senior leadership team and staff working at ward level. Staff reported the senior leadership team was not visible and they did not feel listened to. Throughout this inspection, we saw and staff told us that local leadership in the core services we inspected was visible and had a good knowledge of the risks for their service. They spoke positively of the trust leadership team, and without exception, all staff we spoke with at all levels told us the senior leadership team, including the executive team were visible, accessible and approachable.

The senior leadership team had oversight of the challenges that the organisation faced. The leaders we spoke with, understood the challenges to quality and sustainability, and could identify the actions needed to address these. Throughout the trust, the board were viewed as empowering, visible, accessible, approachable; and highly experienced, with transparent accountability at decision-making levels. The board was seen as strong, and spoke with one voice to ensure consistent messages were communicated to staff throughout the trust.

The chief executive officer and the trust chairman worked well together. The whole executive team had a close working relationship with a good awareness of each other’s portfolio. This was an improvement since our last inspection.

The trust split services into health care groups, and operated a triumvirate management system. Each health care group had an associate clinical director, associate director of nursing, and associate director of operations who worked together. Service matrons, clinical leads for each medical specialty and service managers supported the triumvirate management teams.
The leadership structure was well established and there were clearly defined and visible leadership roles across the health care groups. These leaders demonstrated they had the skills, knowledge, experience and integrity required to undertake their roles and all had an understanding of, and were focussed on the challenges within their service.

At our previous inspection in June 2016, we raised concerns that the trust’s processes for checking whether senior leaders were fit and proper to run the trust had not been embedded. At this inspection, we undertook checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR). This regulation requires providers to have a process to ensure directors were fit to carry out their responsible roles. We found the trust had procedures in place to ensure executive staff were fit and proper to undertake their role. We checked the personnel files of four executive directors to determine if the proper checks had been undertaken. We found that these had been completed.

The FPPR process included comprehensive pre-employment checks that included enhanced Disclosure and Barring Service (DBS) checks, insolvency and bankruptcy checks, disqualified director register checks and occupational health checks. There were further checks on appointment through self-declaration and previous employment checks and on-going assurance through an annual declaration process. This was an improvement since our last inspection in 2016.

At the time of our inspection, chairman had been in post for approximately one year and the chief executive officer (CEO) had been in post for seven months. Although we could see that improvements had been made and have outlined these throughout the report, these had yet to become fully embedded throughout the trust.

Elements of quality improvement were evident, but some work was still required to ensure quality improvement processes became fully embedded. For example, the trust had introduced a quality first programme and the aim of the programme was to put quality first in everything they did and give local teams the tools and the ownerships to make this happen.

**Vision and strategy**

At our inspection in June 2016, we found staff knowledge of the trust’s vision and values was variable and the trust’s vision and values were not clear. At this inspection, we saw the trust had a clear vision that had been introduced following the appointment of the chief executive officer (CEO). This was an improvement since our last inspection in 2016.

The trust’s vision title ‘Your hospital, our future’ was voted for and chosen by staff and was launched at a staff ‘event in a tent’ in September 2017.

The trust’s vision was to reach outstanding and to deliver outstanding healthcare to the local community and for this to be recognised by the Care Quality Commission. The aim of the vision was to continually improve and develop so that they could consistently provide outstanding services to the local population whilst working seamlessly with partners.

In order to meet their ‘your hospital, our future’ vision, the trust had developed a five-year strategy. This was developed around a five ‘P’ plan. The five ‘P’ plan involved the five strategic objectives of the trust:

- Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures
- Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results
• Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership
• Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators
• Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals.

The overall aim of the trust was to build a new hospital and the trust had submitted a strategic outline case, which had been approved. At the time of our inspection, the trust was working on an outline business case to look at potential locations with a new hospital potentially in place by 2025.

Without exception, all staff we spoke with throughout the trust knew and understood the trust’s vision, values and strategy and how these applied to them and the work of their health care group. The senior leadership team were working to ensure the vision, values and strategy became embedded throughout the trust. This was an improvement since our last inspection in 2016.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The chief executive officer (CEO) was the chair of the accountable care partnership (ACP) Board

The trust also had a medicines optimisation strategy, which involved collaborative working across the sustainability and transformation plan (STP) and ACP.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans and reported on this through the trust board meetings.

Although there was a strategy to meet the needs of people with dementia, there was no strategy for meeting the needs of patients with mental health conditions, learning disabilities or autism.

Culture
Without exception, all staff at all levels we spoke with on the wards, in departments and in focus groups reported an open culture. They felt respected, valued, empowered and supported to suggest and instigate change. We met with different groups of staff including pharmacists, consultants, junior doctors, nurses, student nurses, health care assistants, ancillary staff, safeguarding leads, clinical and care group leads, learning and development leads, mental health leads and patient experience leads. All staff we spoke with told us the culture within the organisation had positively changed. Staff expressed they felt proud to work for the trust. However, some staff told us they felt frustrated because they wanted to do their best but felt they couldn’t always give their best due to resource pressures.

Members of the executive team told us how they felt proud of their colleagues and staff throughout the trust. Triumvirate leadership teams told us the culture within the trust had changed and was more positive and that they found the executive team supportive. We heard the healthcare groups were supportive of each other and they worked in collaboration.

Leaders at every level encouraged pride and positivity within the organisation to empower staff to make decisions and to put patients at the centre of their care. Candour, openness, honesty, transparency and challenges to poor practice were encouraged by senior leaders. The senior leadership team actively promoted staff empowerment to drive improvement. Staff felt they could actively raise concerns and report incidents without fear of reprisal and those who did told us they were supported.
Systems and processes were in place to address behaviour and performance that was inconsistent with the trusts vision and values. This was applied regardless of seniority and throughout our inspection we were given examples of where action had been taken.

Following Sir Robert Francis’s Freedom To Speak Up (FTSU) review in 2015, NHS England and NHS Improvement expected all NHS organisations in England to adopt the Freedom To Speak Up: Raising Concerns policy for the NHS (April 2016), as a minimum standard. The trust had a freedom to speak up guardian. The trust submitted information to the National Guardian’s Office on the cases that had been raised with the trusts Freedom to Speak Up Guardian (FTSUG). Between April 2017 and June 2017 there had been seven issues raised with the FTSUG. Four of these included issues with an element of bullying or harassment. Two included inappropriate use of CCTV and one concerned the probity of a senior clinician. A doctor raised one issue, whilst corporate service staff raised the other six issues.

NHS Staff Survey 2016 – results better than average of acute trusts

The trust has two key findings that exceeded the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Quality of appraisals</td>
<td>3.16</td>
<td>3.11</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2016 – results worse than average of acute trusts

The trust has five key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.09</td>
<td>3.33</td>
</tr>
<tr>
<td>Percentage of staff appraised in last 12 months</td>
<td>70%</td>
<td>87%</td>
</tr>
<tr>
<td>Percentage of staff agreeing that their role makes a difference to patients / service Users</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>43%</td>
<td>51%</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.37</td>
<td>3.61</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2016 - link)

The staff survey results reflect the pressure staff were under despite on-going recruitment into roles which we heard about from staff on the wards and departments. However, it demonstrates the positive attitude of the staff working at the trust.
Staff Diversity

The trust were unable to provide breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

Workforce race equality standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
<th>Your Trust in 2016</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>30%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>36%</td>
<td>26%</td>
<td>41%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>35%</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White</td>
<td>82%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>68%</td>
<td>76%</td>
<td>61%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>19%</td>
<td>14%</td>
<td>12%</td>
</tr>
</tbody>
</table>

All four of the questions showed a statistically significant difference in score between White and BME staff:

(Source: NHS Staff Survey 2016 - link)

Of the executive board members at the trust, none were British Minority Ethnic (BME) and 37.5% were female.

Of the non-executive board members, none were BME and 25% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
</tbody>
</table>
The trust had a 2017/18 action plan to address the WRES standards they were presently not meeting. The action plan detailed the trust’s current position, the WRES indicators and action to be taken. However, the action plan did not have a target date for completion, an action lead or an actual completion date documented. Therefore, it could not be effectively monitored through the appropriate governance structures. When we interviewed the director for human resources, they were not sure where the trust was up to with WRES.

### Sickness absence rates

The trust’s sickness absence levels from August 2016 to June 2017 were below the England average. This is potentially a reflection of the staff’s loyalty to the hospital and ensuring the provision of a patient centred service.

![Sickness absence rates graph](image)

(Source: NHS Digital)

### General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey, the trust performed worse than expected for three indicators: clinical supervision, feedback and induction and the same as expected for the remaining 11 indicators.

(Source: General Medical Council National Training Scheme Survey)
**Governance**

The trust had effective structures, systems and processes in place to support the delivery of its strategy and provide safe and good quality patient care, including sub-board committees, divisional committees and team meetings. The trust board met regularly and provided an opportunity for scrutiny to members of the public as well as internally.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. The trust board was focused on the key priorities for the trust. The trust board considered reports from a number of committees including the performance and finance committee, quality and safety committee and the audit committee. A workforce committee had also been established six months prior to our inspection to focus on recruitment, retention and vacancies throughout the trust.

There was a risk management group, which fed into the executive management board, and in turn fed into the trust board. A serious incident group (SIG) fed into the quality and safety committee, which was chaired by the chief medical officer and the chief nurse, and was held on a daily basis. In addition, the quality first board and the oversight group fed into the trust board.

Health care groups within the trust had monthly meetings to discuss performance, risk, safety and quality metrics. The appropriate committee then considered the outcomes of the divisional meetings. Triumvirate leaders we spoke with throughout our inspection could describe the escalation of information from the health care group through board sub committees to the board.

Without exception, the risks identified by members of staff at all levels and across the health care groups matched those that were on the trust’s risk register. The top four risks were workforce capacity, estates and infrastructure, failure to achieve the four hour emergency department constitutional standard and finance.

During the period of special measures oversight meetings were convened and attended by a number of stakeholders to monitor progress against issues that had been reported at our previous inspection. The trust had engaged well with this programme of monitoring. They encouraged teams to present at these meetings areas of challenge and how they had addressed our concerns. We saw that our concerns had been taken on board by the trust and its staff and heard staff speak passionately about the improvements they had made to services in order to improve patient care. Stakeholders were able to constructively challenge the staff groups making these changes at ground level and hear about the impact these changes were having to teams and patients. This had been a positive driver for the trust in empowering staff to make quality improvements in their area.

The trust had a Quality First Programme, which was led by an Associate Clinical Director, Associate Medical Director and a Deputy Director of Quality Improvements. It was a multidisciplinary team with a focus on developing the workforce, systems and ways of working to prepare for transfer to a new hospital environment. The aim of the programme was to put quality first in everything they did and give local teams the tools and the ownerships to make this happen. The team described wanting to start a ‘revolution’ within the trust. There were a number of quality improvement projects in place, which supported the trusts overarching quality improvement plan. There was an accountability framework in place for the quality first programme.

As part of our well-led inspection, we observed a private board meeting, which was attended by eight executive directors and eight non-executive directors. This gave us the opportunity to
observe the interaction and influence of the NEDs as part of the overall leadership of the trust. At this meeting, we observed constructive and appropriate challenge among the leadership team, from the NEDs to the executive directors. Board members were open to challenge and challenges were presented in a professional manner. All the NEDs we spoke with were positive about the changes in leadership at the trust.

Following our previous inspection in June 2016, we raised concerns about risk management processes throughout the trust. Throughout this inspection, we saw improvements in the risk management process. The trust provided their 2017/18 Board Assurance Framework (BAF), which detailed the trusts strategic objectives of the five ‘P’s and accompanying risks.

There had been significant improvements in the BAF since our last inspection. The BAF was a live document and each risk was owned and reviewed on a monthly basis by a lead executive and reviewed bi-monthly at a trust board committee. The risk management group received a monthly update of the BAF risks. The BAF included a clear synopsis of the principal risks, an evaluation of risk exposure and target ratings. These areas are considered good practice. There was evidence of monthly reviews of the BAF at all formal meetings of the board, sub and executive committees.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts. There was an open and supportive reporting culture, where staff were encouraged to report not just incidents which had happened, but also ‘near misses’.

Since our last inspection, the trust had moved to an electronic risk management tool. The risk team reported things had improved since its introduction. The risk management group was chaired by the Chief Medical Officer and met monthly. The group reported to the executive management board and then to the trust board. This was an improvement since our inspection in June 2016.

Serious incidents were reviewed every weekday at a group known as the ‘Serious Incident Group’ (SIG). The Chief Medical Officer and the Chief Nurse chaired the SIG meetings. This daily meeting ensured timely responses to immediate actions that were required following a serious incident. Incident reporting numbers had been increasing, although the level of harm to patients had not.

The trust had one integrated risk register, which combined clinical and non-clinical risks. Each healthcare group had their own risk register and any risks with a score of 15 or above were escalated to the trusts overall risk management group. At our previous inspection there had been a myriad of risk tools used by the trust to identify and monitor risk. Due to the number of risk documents we were concerned that the trust did not have a clear picture of the top risks in the organisation. However on this inspection we found that there was greater clarity and cohesiveness around what the top risks for the organisation were through a single streamlined process of management of risk.

The risk management team had focused on improving feedback for staff after they had reported an incident. Almost all staff were now given feedback following the submission of an incident report. The next priority for the senior leadership team was to review the quality of the feedback. The corporate risk team buddied with the risk teams within the healthcare groups. They reported this had helped to develop and foster better working relationships.

The trust still had challenges with timely response to serious incidents and not all serious incidents were investigated in line with the policy. The process for investigations had been revised and more checkpoints had been built in to flag when an investigation was at risk of slipping off its trajectory. It was also designed to hold the investigator to account.
There was a lack of governance, performance and management arrangements relating to Mental Health Act (MHA) administration and the provision of psychiatric liaison services. There were no board reports or an executive mental health lead for MHA provision.

Management of risks, issues and performance

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£196.1 million</td>
<td>£209.7 million</td>
</tr>
<tr>
<td>Surplus / (deficit)</td>
<td>(£37.7 million)</td>
<td>(£26.7 million)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£233.8 million</td>
<td>£236.5 million</td>
</tr>
<tr>
<td>Budget / (deficit)</td>
<td>(£28.6 million)</td>
<td>(£29.7 million)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust provided a document detailing their 14 highest profile risks. Each of these had a current risk score of 12 or higher. Eight had a risk of 16 or higher. The trust indicated that its greatest risks were in outcomes, workforce capacity and estates and infrastructure.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk Level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td><strong>Outcomes</strong>: Inconsistent outcomes in clinical quality, safety, patient experience, 'higher than expected' mortality and failure to deliver 4 hour ED standard.</td>
<td>20</td>
<td>15</td>
<td>07/07/2017</td>
</tr>
<tr>
<td>1.2</td>
<td><strong>EPR</strong>: Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records</td>
<td>16</td>
<td>12</td>
<td>July 2017</td>
</tr>
<tr>
<td>1.3</td>
<td><strong>Coding Risk</strong>: Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery</td>
<td>16</td>
<td>12</td>
<td>11/07/2017</td>
</tr>
<tr>
<td>2.1</td>
<td><strong>Workforce Capacity</strong>: Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.</td>
<td>20</td>
<td>12</td>
<td>15/05/2017</td>
</tr>
<tr>
<td>2.2</td>
<td><strong>Clinical Leadership and Engagement</strong>: Inconsistent Clinical Leadership &amp; Engagement in strategy, operations, performance and delivery which impairs Trusts reputation &amp; sustainability.</td>
<td>16</td>
<td>12</td>
<td>07/07/2017</td>
</tr>
<tr>
<td>2.3</td>
<td><strong>Internal Engagement</strong>: Failure to communicate key messages and organisational changes to front line staff.</td>
<td>12</td>
<td>6</td>
<td>15/05/2017</td>
</tr>
<tr>
<td>2.4</td>
<td><strong>Workforce Productivity</strong>: Concerns about falling productivity and increasing layers of management</td>
<td>12</td>
<td>9</td>
<td>15/05/2017</td>
</tr>
<tr>
<td></td>
<td>Estates &amp; Infrastructure: Concerns about potential failure of the Trust's Estate &amp; Infrastructure and consequences for service delivery.</td>
<td>20</td>
<td>8</td>
<td>11/05/2017</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3.2</td>
<td>Health Economy Stability &amp; Joined up Approach: Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.</td>
<td>16</td>
<td>12</td>
<td>05/07/2017</td>
</tr>
<tr>
<td>3.3</td>
<td>Financial and Clinical Sustainability across health and social care system: Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.</td>
<td>16</td>
<td>12</td>
<td>05/07/2017</td>
</tr>
<tr>
<td>3.4</td>
<td>Strategic Change and Organisational Structure: Capacity &amp; capability of senior Trust leaders to influence both internally and externally the required strategic changes.</td>
<td>12</td>
<td>8</td>
<td>05/07/2017</td>
</tr>
<tr>
<td>3.5</td>
<td>Sustainability of local services: Failure to ensure sustainable local services.</td>
<td>16</td>
<td>12</td>
<td>05/07/2017</td>
</tr>
<tr>
<td>4.1</td>
<td>Supporting Functions (including Finance, IT, HR and Estates and Facilities): Concerns around the need to modernise the systems, processes, structures, capacity &amp; capability of the business support functions.</td>
<td>16</td>
<td>12</td>
<td>06/06/2017</td>
</tr>
<tr>
<td>5.1</td>
<td>Finance: Concerns around failure to meet financial plan including cash shortfall.</td>
<td>16</td>
<td>10</td>
<td>06/06/2017</td>
</tr>
</tbody>
</table>

Further information can be found in the Medicine, Urgent and Emergency Care and Adult Safeguarding risk register or the Corporate Risk Register

*(Source: Trust Corporate Risk Register / Board assurance framework)*

**Information management**

The trust governance framework including committee reports and performance reports the board was able to receive relevant and where required, targeted information on quality, safety and the overall position of the trust.

Board papers contained the necessary information to monitor the performance of the trust. Dashboard and other performance data were made available to managers and team members within in the organisation and gave information as to performance, safety and quality in their area.

The trust was aware of its performance using key performance indicators (KPIs) and other metrics. This data fed into a board assurance framework.

**Engagement**

At our last inspection in June 2016, staff reported a disconnect between the board and those working at ward level. At this inspection, without exception, staff we spoke with told us that communication with the board had significantly improved. Staff were extremely positive about the open lines of communication with the executive board. We saw many examples of where improvements had been made to ensure staff engagement.

Every Tuesday morning the executive team held an executive briefing in the staff canteen. This was open to all staff and we attended the briefing as part of our inspection. The briefing lasted approximately half an hour and gave the executive team the opportunity to update staff with any significant news, make any special announcements and to acknowledge any challenges across the trust. It also gave staff the opportunity to ask questions of the executive team. The briefing was
well attended by staff of all grades and all areas of the trust. Staff we spoke with told us the briefing session was always well attended.

The chief executive officer (CEO) sent out a weekly email update, which all staff had access to and also had a separate email address called ‘Ask Lance’ for any staff member to email them with any query or concern. We spoke with staff who told us they had used this form of communication to raise queries. They confirmed they would usually get a response very quickly and always within two days.

Trust wide there was staff recognition in the form of an ‘Amazing People Award’ and staff across the trust were able to tell us about the award ceremony that took place.

In September 2017 the trust held an ‘event in a tent’. This was a marquee set up in the hospital grounds organised to launch the ‘Your future, our hospital’ improvement plan. The event was open to staff, local community and stakeholders/partners. Staff at all levels were able to tell us about this event. The event in a tent also gave the trust an opportunity to recruit new staff.

In November 2017, the trust ran a ‘Fab change week’ which was themed ‘ready, steady, go. This was to get staff to engage with the five ‘P’s and to make a pledge in relation to the five ‘P’s. each day focussed on a different priority.

Staff had been engaged with and involved in the redesign of the new emergency department.

Communication systems were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

We saw evidence of a number of positive and collaborative relationships the trust had with external partners, these included other acute NHS trusts, primary medical services and local colleges and universities. This ensured that they could deliver service to meet the needs of the local population.

Recruitment and retention had been a concern throughout the trust and the trust had a comprehensive retention improvement plan. In addition, the trust had introduced an initiative called ‘itchy feet’, which enabled staff who were thinking of leaving the trust to email a ‘stay@pah.nhs.uk’ email address to identify themselves to access a personal conversation about what might help them to stay at the trust. In addition, the trust was also starting to run career clinics to identify career opportunities for staff.

The trust was committed to supporting staff to develop. In recruiting health care assistants, the trust had recognised a number of applicants were being rejected because they had not achieved a suitable qualification in maths and English. In order to overcome this concern, the trust had linked in with a local college to support suitable candidates to achieve the relevant qualifications in maths and English to enable to undertake this role.

**Learning, continuous improvement and innovation**

The board undertook a self-assessment against the new well-Led framework, in June 2017, with the aim of identifying actions for improvement, together with future items for board development.

There was a strong focus on continuous learning and improvement at all levels of the trust and staff at all levels spoke of a culture that supported innovation. For example, critical care had recently (October 2017) implemented a secure medicines return bin, which meant staff could
return any unused medicines on the unit to the pharmacy for recycling or disposal. Pharmacy staff told us that in the first month of use the bin had saved the hospital £1200 by recycling unused medicines. This idea came from a staff member on the critical care unit.

The trust took complaints seriously. The trust had a Patient Advice and Liaison Service (PALS), which was easily accessible within the hospital, and information on how to contact PALS was available in all ward areas. Information on how to make formal complaint was also displayed in ward areas for patients and relatives. In addition, complaints were overseen by a patient experience team, which included the chief nurse, chairman, who was also the chair of the quality and safety committee, the head of patient experience, a patient experience manager and a patient experience facilitator.

The trust was asked to comment on their targets for responding to complaints and current performance against the following targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>95.7%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>180 days*</td>
<td>98.97%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>180 days</td>
<td>98.97%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td></td>
<td>2,677</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

The trust received formal 241 complaints from August 2016 to July 2017. A breakdown by core service is below.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>92</td>
<td>38.17%</td>
</tr>
<tr>
<td>Surgery</td>
<td>76</td>
<td>31.54%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>40</td>
<td>16.60%</td>
</tr>
<tr>
<td>Maternity</td>
<td>18</td>
<td>7.47%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>10</td>
<td>4.15%</td>
</tr>
<tr>
<td>Children</td>
<td>3</td>
<td>1.24%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.83%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab - link)

The trust board received a report on complaints once every three months. In addition, the Quality and Safety Committee (QSC) received information about complaints every two months.
Information relating to complaints was shared at all levels. The trust board and QSC heard patient stories in the form of deep dives into specific complaints. A case had recently been presented at board level relating to a complaint about communication in end of life care, which had become part of a communication skills micro teaching program called ‘Talk to Me’. Safety huddles also took place at ward level.

Once the patient experience team received a complaint, they allocated it to the clinical director and associate nurse director of the appropriate health care group, who appointed a lead investigator. Once investigations had been completed, an executive clinical reviewer submitted them to the patient experience team for review. Either the chief nurse, deputy chief nurse or the chief medical officer undertook this. The chief executive officer or their deputy signed all complaint letters.

The trust acknowledged complaints within three working days and offered all complainants a meeting with senior trust staff to discuss the complaint face-to-face. The uptake for these meetings had been good and the feedback the trust received from these meetings was positive.

The trust had responded to the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 CQC report ‘Learning, candour and accountability’. The learning from deaths guidance required NHS trusts to produce and publish an updated policy on learning from death. The trust had a ‘learning from every adult death’ policy, which had been ratified in June 2017 and a standard operating procedure for initiating a rapid review of death in children. This was due for review in February 2018. The executive lead for information and learning from deaths was the chief medical officer. There was also a non-executive director who oversaw the information and learning from deaths.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the services at the Princess Alexandra Hospital had been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medicine (including older people's care)</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>Surgery</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Commission for the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>N/A</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>N/A</td>
</tr>
<tr>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>N/A</td>
</tr>
<tr>
<td>ISO 13485 accreditation</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Device Directive 93/42/EEC</td>
<td>N/A</td>
</tr>
<tr>
<td>UKAS : Physiological Services accreditation (IQIPS)</td>
<td>N/A</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) - PICU (Psychiatric Intensive Care Units)</td>
<td>Acute wards for adults of working age and psychiatric intensive care units</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) - AT (Assessment and triage wards)</td>
<td>Acute wards for adults of working age and psychiatric intensive care units</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) - OP (Wards for older people)</td>
<td>Wards for older people with mental health problems</td>
</tr>
<tr>
<td>Accreditation for Inpatient Mental Health Services (AIMS) - Rehab (Rehabilitation wards)</td>
<td>Long stay / rehabilitation mental health wards for working age adults</td>
</tr>
<tr>
<td>Quality Network for Inpatient Learning Disability Services (QNLD)</td>
<td>Wards for people with learning disabilities or autism</td>
</tr>
<tr>
<td>Quality Network for Inpatient CAMHS (QNIC)</td>
<td>Child and adolescent mental health wards</td>
</tr>
<tr>
<td>Quality Network for Community CAMHS (QNCC)</td>
<td>Specialist community mental health services for children and young people</td>
</tr>
<tr>
<td>Quality Network for Perinatal Mental Health Services (QNPMH)</td>
<td>N/A</td>
</tr>
<tr>
<td>ECT Accreditation Scheme (ECTAS)</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychiatric Liaison Accreditation Network (PLAN)</td>
<td>N/A</td>
</tr>
<tr>
<td>Memory Services National Accreditation Programme (MSNAP)</td>
<td>N/A</td>
</tr>
<tr>
<td>Accreditation for Psychological Therapies Services (APPTS)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Urgent and emergency care

Facts and data about this service

The urgent and emergency care department at the Princess Alexandra Hospital is located in Harlow, Essex. In July 2017, the department went through a period of re-design to improve the department layout and include a new clinical decisions unit (CDU), surgical assessment unit (SAU) and paediatric urgent and emergency care department. At the time of our inspection the CDU was not open and paediatric urgent and emergency care department was in its early stages of completion. The urgent and emergency care department at the Princess Alexandra Hospital provides a 24-hour, seven day a week service to the local area.

From September 2016 to August 2017, there were 100,689 urgent and emergency care attendances at the Princess Alexandra Hospital NHS Trust. Of these attendances, 19.7% resulted in admissions, which is lower than the England average of 21.6%. The department had 26,952 attendances for children during the same reporting period. The department also had 21,708 attendees arriving by ambulance during the same period.

The urgent and emergency care department provides consultant led care with a dedicated general practitioner (GP) streaming area to direct patients to the most appropriate care pathway. Since the refurbishment of the emergency department the resuscitation area had acquired four beds to provide care for both adult and paediatric patients, and is located adjacent to the dedicated ambulance entrance. The majors area has 17 cubicles and a mental health assessment room. The minors areas of the department consists of 10 cubicles to accommodate both patient trolleys and chairs.

The department has a designated children’s emergency department, which is open 24 hours a day, seven days a week. The paediatric emergency department is accessible from the main emergency department and is secured with swipe card access. Relatives and patients access this area with permission from staff. The paediatric emergency department has two assessment rooms, a high dependency room and cubicle space for seven patient trolleys or cot beds.

The Care Quality Commission last inspected the emergency department at the Princess Alexandra Hospital in June and July 2016 prior to the re-design of the department. At that time, we rated it as inadequate overall. We rated safe and well led as inadequate, effective and responsive as requires improvement and caring as good. Part of this inspection was to look at the changes the department had made to address our concerns.

Our inspection was announced at short notice. Before our inspection, we reviewed information that we held about this service and information requested from the trust.

During this inspection, we visited all areas located within the adult and paediatric emergency department, emergency nurse practitioner treatment area and public waiting areas.

Throughout our inspection, we spoke with 12 patients and relatives of people who had used the service. We observed staff giving care to both adults and children and we reviewed 50 patient care records in both paper and electronic format to assess for completeness and accuracy. We also reviewed performance information from and about the trust.

We spoke with 18 members of staff from a variety of grades. This included consultants, middle
grade and junior grade doctors, senior managers, matrons, nurses, health care assistants and administrative staff.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at The Princess Alexandra Hospital NHS Trust compared to all acute trusts in England.**

There were 101,152 attendances from April 2016 to March 2017 at The Princess Alexandra Hospital NHS Trust as indicated in the chart above.

*(Source: NHS England)*

**Urgent and Emergency Care attendances resulting in an admission**

The percentage of A&E attendances at this trust, which resulted in an admission, decreased by
5.7% from year 1 to year 2. In year 2, rates were higher than the England average.

(Source: NHS England)

**Urgent and Emergency Care attendances by disposal method**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>19,881</td>
</tr>
<tr>
<td>Discharged*</td>
<td>57,838</td>
</tr>
<tr>
<td>Referred*</td>
<td>17,759</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,460</td>
</tr>
<tr>
<td>Died in department</td>
<td>113</td>
</tr>
<tr>
<td>Left department#</td>
<td>3,783</td>
</tr>
<tr>
<td>Not known</td>
<td>13</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

The trust had a programme of mandatory training for staff. Mandatory training subjects included, for example, fire safety, moving and handling, information governance, equality and diversity, learning disability awareness, dementia awareness and infection control. Safeguarding training included information on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Mental health training was not provided as part of mandatory training.

Mandatory training was delivered face-to-face and through an online learning management system.

The urgent and emergency care department had a dedicated practice development nurse who managed staff attendance at mandatory training.

Managers held mandatory training compliance records in each area of the department. Training compliance was red amber green (RAG) rated to indicate when training was due to expire. Managers displayed training data in staff areas within the department to enable staff to review when training was required.

We spoke with two staff who told us they were able to access mandatory training when required.

The trust set a target of 95% for completion of mandatory training. Overall, the emergency department had a 66% completion rate, which did not meet the trust target.

Medical & dental staff failed to meet the trust completion target of 95% for mandatory training for all five modules. The lowest scoring module was fire safety with 42%.
Nursing & midwifery staff failed to meet the trust completion target of 95% for mandatory training for all five modules. The lowest scoring module was infection control level 2 with 65%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>18</td>
<td>27</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>33</td>
<td>57</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>29</td>
<td>57</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>14</td>
<td>30</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>24</td>
<td>57</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We requested up to date training compliance data following our inspection. Data provided by the trust showed that medical staff compliance with mandatory training had improved. However, few subjects had met the trust’s compliance rate of 95%. Subjects that did not meet the target included, but were not limited to; adult and paediatric basic life support (41%), conflict resolution (75%), dementia awareness (75%), fire (47%), infection prevention and control – level 2 (61%) and values and behaviours (72%).

Nursing staff compliance with mandatory training had improved with 100% of nurses completing conflict resolution, equality, diversity and human rights, information governance, learning disability awareness and values and behaviour. Compliance was not met in subjects including, but not limited to: fire (74%) and infection prevention and control – level 2 (69%). Staff in the adult emergency department failed to meet the trusts target of 95% compliance in training for adult and paediatric basic life support (55%), immediate life support (91%) and paediatric immediate life support (86%). However, 93% of staff working in the paediatric emergency department had completed paediatric immediate life support training.

Five out of nine security staff had received training in mental health awareness, however; mental health awareness was to form a core part of induction training for this group of staff from 1 February 2018.

Staff told us they received training in identifying and managing patients with sepsis. Sepsis is a severe infection, which spreads in the bloodstream. A sepsis tool was available for completion on patients records. Staff had access to a policy on Sepsis.

We requested training compliance data for medical and nursing staff, which showed that 74% all
emergency department staff had received this training.

**Safeguarding**

The department had systems and processes in place to safeguard adults and children who were from abuse or harm. There were up-to-date safeguarding policies and procedures in place, which were accessible to staff through the trust’s intranet site. Staff demonstrated a good understanding of the trusts safeguarding policies, procedures and what to do should a safeguarding concern arise.

The trust set a target of 95% for completion of safeguarding training. Overall, the emergency department had a safeguarding completion rate of 78% which failed to meet the trust target.

Medical & dental staff failed to meet the trust completion target of 95% for safeguarding training for two modules. The lowest scoring module was safeguarding adults level 2 with 50%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children level 2</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults level 2</td>
<td>15</td>
<td>30</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing & midwifery staff failed to meet the trust completion target of 95% for safeguarding adults level 2 and 90% for safeguarding children level 2 training. The lowest scoring module was safeguarding children’s level two with 71%.

Safeguarding children was classed as mandatory training for clinical staff working within the adult and paediatric emergency department.

As of 8 November 2017, 76% of eligible staff in the paediatric emergency department had received training in safeguarding children level three, which was below the trust’s compliance target of 95%.

We requested up to date training compliance data after our inspection. Safeguarding children level three training compliance had improved. Data showed that 90% of staff within the paediatric department had received children’s safeguarding level three training.

Within the adult emergency department, 100% of staff had received adult safeguarding level one training and 76% of staff had received level two training. Data showed that 96% of applicable staff had received safeguarding children level one training, 85% level two and 82% level three. Although this was below the trust’s target of 95% compliance, it was an improving picture. Staff received training in child sexual exploitation (CSE) and female genital mutilation (FGM) as part of their mandatory safeguarding training sessions.

Information regarding the actions to take following a safeguarding disclosure or identifying a concern was displayed in the paediatric emergency department.

The ‘Daisy Project’ was a programme designed to provide patients and visitors with a safe place to discuss concerns around domestic violence. We saw that project information was displayed in staff restroom areas. Staff we spoke with gave an example of when the Daisy team had attended
the paediatric emergency department to support the relative of an admitted patient.

Safeguarding information was displayed in the department’s staff room and training areas to provide staff with guidance and access to additional advice from the local safeguarding team and safeguarding telephone contact numbers if required.

Electronic medical records contained a ‘red flag’ to identify children or adults that had been previously identified as vulnerable or who may be at risk. This enabled staff to identify patients likely to be at risk from abuse or neglect and use appropriate strategies to promote their health and wellbeing.

The emergency department maintained regular contact with the safeguarding team, who visited the department on a daily basis and saw all adult and paediatric patients that had been identified as having a safeguarding concern. We saw the safeguarding team were visible within the emergency department throughout our inspection.

We spoke with the adult safeguarding lead for the hospital. They told us that multi-agency meetings with social care and children’s centres took place on a regular basis to provide a safe forum for discussion.

The protocol for sedation was not specifically related to the care of patients experiencing a mental health condition. The procedural sedation proforma was related to medical conditions and not tailored to specifically meet the needs of patients experiencing a mental health illness.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults level 2</td>
<td>57</td>
<td>69</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children’s level 2</td>
<td>20</td>
<td>28</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The emergency department had effective systems and processes in place to maintain cleanliness and control infection.

Staff had electronic access to an infection prevention and control policy within both the adult and paediatric emergency departments.

The emergency department was visibly clean. Staff kept corridors and waiting areas free from clutter and storage areas were clean and tidy with stock, which was positioned off the floor to reduce the risk of cross contamination and enable effective cleaning to take place.

Staff and visitors had access to hand hygiene facilities. Hand sanitising dispensers were located at regular intervals throughout the adult and paediatric emergency departments, corridors and waiting areas.

Staff had access to personal protective equipment (PPE) such as aprons and gloves and regular intervals throughout the department. Staff demonstrated the effective use of PPE with gloves and aprons disposed of in the correct clinical waste bins.
Staff routinely cleaned equipment and used ‘I am clean’ stickers, to assure staff that it was clean and ready for use. Stickers were in frequent use throughout the department on various pieces of equipment and trolley beds.

Cubicle curtains were disposable, visibly clean and replaced within the four weeks prior to our inspection.

Systems and processes were in place to treat patients with infectious diseases such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (c-diff). This included the use of single cubicle isolation rooms to prevent the spread of infection.

The department used infection prevention and control (IPC) posters on the doors of cubicles to provide IPC information for staff and visitors. We saw posters in use during our inspection.

Staff segregated and labelled clinical waste and domestic waste bins correctly. This meant staff could clearly identify the appropriate receptacle to dispose of waste. Sharps (needles) bins were located in all clinical areas. Sharps bins had been correctly assembled and labelled to identify when the bin was first used. All sharps bins were within a safe fill limit therefore reducing the risk of needle stick injury.

Domestic staff cleaned the department at regular intervals during our inspection and completed cleaning check sheets for the five days prior to our inspection.

Domestic staff inspected the public toilets within the department at regular intervals. We reviewed cleaning check sheets for the five days prior to our inspection, which demonstrated, checks and cleaning had taken place.

The toys within the paediatric emergency department were part of a scheduled daily clean. We reviewed the records and noted that cleaning had taken place on a daily basis.

We requested environmental hygiene audits for the three months prior to our inspection. The trust provided data for the months of September 2017 and November 2017 in relation to the adult emergency department (ED). The adult ED scored 98% compliance in relation to environmental hygiene. Data relating to the paediatric emergency department was provided for the month of September 2017, which demonstrated a 96% compliance rate. No data was provided for the months of October 2017 and November 2017.

During our inspection, we observed staff following appropriate hand hygiene practices. This included staff washing their hands prior to and after patient contact to prevent the spread of infection. This was in line with the National Institute of Health and Care Excellence (NICE) Quality Statement 3. However, hand hygiene audit data from May 2017 to October 2017 showed the adult emergency department was failing to achieve the 95% target set by the trust for hand hygiene compliance. Compliance ranged between 61% and 81% however, we noted that no data was returned for the months of May 2017 and September 2017 as no data was entered on to the spreadsheet for these months. The department was actively addressing non-compliance with hand hygiene by discussing this topic at daily huddle meetings.

All clinical staff had their arms bare below the elbow, in line with trust policy to prevent the spread of infection.

**Environment and equipment**

The design, maintenance and use of facilities met the need of patients. There were systems in place to ensure that the regular maintenance and use of equipment kept people safe.

The department was designed to aid flow and provide access to diagnostic imaging facilities, theatres and the helicopter landing pad.
The adult emergency department (ED) consisted of four resuscitation cubicles, 17 majors cubicles, five rapid assessment and treatment (RAT) cubicles and 10 minors cubicles. The minor injuries unit was located adjacent to the ED and consisted of three cubicles and a waiting area. The ED also contained two GP assessment rooms to enable the streaming of patients to appropriate areas including referral to speciality or to the patient’s own GP if clinically appropriate.

The majority of bays in both the adult and children’s ED, including the mental health assessment room were all in view of the nurse’s stations. This enabled staff to have oversight of acutely ill patients within this area.

At the time of our inspection, the paediatric ED did not have a dedicated mental health cubicle or assessment area, but staff showed us an area which they could make safe and where they could take children and where appropriate their guardian to ensure safety.

The children’s ED could be accessed by the main emergency department. We saw clear signage to direct relatives and patients to this area. All paediatric areas were secure with restricted access by swipe card for staff only. There was clear audio and visual separation of all children’s areas from the adult ED.

The emergency department design allowed access to appropriate clinical areas, including the resuscitation bays and paediatric department. The ambulance arrival bay and helipad were located adjacent to the department to allow crews access in a safe and timely manner.

Self-presenting patients arrived to the department and were booked in at the reception desk. The reception area was well lit, spacious and provided user-friendly reception desk access at varying heights for patients with additional mobility needs.

Reception staff had direct oversight of all patients within the waiting area. Protective screens partially covered the reception staff; however, the trust were due to extend the screens to provide appropriate protection for staff. The oversight of patient’s within the waiting area had improved.

An emergency buzzer was located at the reception desk so that staff could summon assistance in the event of a medical emergency. The waiting area had adequate seating to accommodate those presenting to the department.

The entrance to the majors’ area of the department, from the public waiting area had key coded doors preventing unauthorised access. However, on numerous occasions we found these doors to be propped open. This meant those who were unauthorised to do so could access this area of the department. We escalated our concerns to the Matron who took immediate action to secure this area. Future observations showed the doors closed.

The rear of the ED was accessible to the public from a unlocked door in the public café area. We raised our concerns to the executive management team who took immediate action to secure this area, pending installation of new locks. After we raised our concerns, security staff were put in place to oversee this area and to ensure only authorised personnel could access the department.

Ambulance crews arrived by a dedicated entrance adjacent to the resuscitation room. This meant staff could accept acutely unwell patients directly into the department.

The main resuscitation area had dedicated paediatric equipment. In addition, the children’s ED had a dedicated high dependency room for acutely unwell patients.

The emergency nurse practitioner area was located adjacent to the emergency department. All equipment and consumables within this area were in date and up to date with servicing.

The x-ray department was located adjacent to the adult ED enabling easy patient and staff access to these facilities.
Staff saw children with mental health conditions within the paediatric ED and placed patients in high visibility areas, to ensure oversight from staff.

The emergency department displayed a daily environmental and equipment safety checklist. This provided staff with a visual reminder for checking equipment within the department for example, commodes, resuscitation trolleys, and fridges. Each check was allocated to a staff member to ensure ownership was taken for each task.

We reviewed a sample of equipment for adherence to recommended servicing and maintenance plans. Sample of defibrillators, ECG machines and monitors were all within the recommended service period.

There were three resuscitation trolleys in the ED, one in the children’s ED, one in the minor injury unit and one in the majors department. Equipment was located to enable effective access in the event of a medical emergency. All trolleys were tagged to indicate whether equipment had been tampered with.

Staff carried out resuscitation equipment checks on a daily basis and undertook monthly checks on consumable equipment.

A difficult airway kit was located in the resuscitation room. All equipment was in date and available for use in an emergency. This was an improvement since our previous inspection. Difficult airway equipment was on hand to enable staff to access this equipment in the event of an emergency.

The department had introduced pre-packed consumable equipment trays on resuscitation trolleys in order to ensure staff had access to necessary items in a timely manner. We reviewed a sample of consumable equipment within the department and found it was all in date.

We reviewed check sheets for the five days prior to our inspection. Staff had checked all resuscitation equipment within the majors, children’s and resuscitation areas as per schedule and all consumable equipment within these areas were in date. All trolleys were tagged with correctly documented tag numbers. This meant that staff had access to emergency equipment that was in date and had been safely maintained. Resuscitation equipment was being checked on a regular basis. This was an improvement in comparison to our previous inspection.

The department had a quality indicator dashboard in place, which utilised a red, amber green (RAG) rating to indicate performance in relation to equipment checking. For September, October and November 2017, compliance with resuscitation trolley checks ranged between 96% and 100%.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust’s scored “worse than” other trusts for two of the five Emergency Department Survey questions relevant to safety. The trust scored “about the same” as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the</td>
<td>6.4</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
emergency department staff?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey – September 2016)

The department had a patient triage, assessment, and streaming processes in place. However, at periods of high demand, staff did not routinely assess patients within 15 minutes of arrival due to the volume of patients within the department. Despite this, the number of patients seen within 15 minutes of arrival had improved since our last inspection.

Between the hours of 10am to 10pm, the department used a streaming nurse to direct self-presenting patients to the most appropriate area, for example; GP service, rapid assessment and triage (RAT) area or the minor injury unit. The RAT area allowed staff to prioritise the most clinically unwell patients upon arrival to the department.

Patients were seen and treated in order of clinical priority. The RAT area was located adjacent to the waiting area and ambulance handover point so staff could see the patient at point of handover. This was an improvement since our previous inspection.

An emergency nurse practitioner (ENP) oversaw the RAT area to ensure flow within this area took place based on risk and in a timely manner. Staff within the RAT area had a named doctor to escalate concerns to in the event of clinical concerns being identified or patient deterioration.

The corridor had dedicated paramedics to ensure that clinical deterioration was identified in a timely manner for patients waiting within this area. Staff had access to a named doctor and a named nurse to escalate clinical concerns about patients. We saw this process in use and saw that it was an improvement on our previous inspection.

The department had recently introduced a patient safety checklist based on the Bristol Safety Checklist. The checklist included key areas of observations and care, dependent on the length of time a patient had been in the department. We reviewed records to ascertain whether the patient safety checklist had been completed. Our review demonstrated that two out of 11 medical records showed the patient safety checklist had been appropriately completed. This process had been in use two weeks. We were therefore not assured the process was embedded, as documentation did not consistently demonstrate the use of this tool.

The trust had no data available to show compliance with the safety checklist due to its recent implementation two weeks prior to our inspection. However, a team within the hospital had been tasked to audit this particular area once enough data had been collated.
Emergency ambulance crews pre-alerted the emergency department by telephone when on route with a critically unwell patient. Patients arriving by ambulance as a priority (blue light call) were accepted and assessed immediately in the resuscitation area. This was an improvement since our previous inspection. The resuscitation area was located next to the ambulance arrival area. During our inspection, we observed two patients arriving by ambulance. Both patients were accepted and assessed immediately by the receiving clinicians within the resuscitation area.

The RAT area was staffed with doctors and nurses to enable the timely assessment of presenting patients. This enabled staff to detect critical illness or injury in a timely manner. A consultant oversaw the RAT area with an emergency nurse practitioner (ENP) supporting the operation of this area.

We spoke with two reception staff who regularly worked in the ED. Whilst they had not received specific training in patient deterioration, both staff described how responsive the nurses and doctors within the department were if they had concerns about the condition of a patient. Reception staff described the use of the emergency buzzer in the waiting area and that clinical staff always responded immediately.

There was clear information on display in the waiting area to encourage patients to report deterioration in their condition to reception staff immediately.

The department used an early warning score (EWS) as part of initial assessment for all patients that presented to the department. We reviewed the electronic initial assessment of five patients and noted that all had a documented early warning score. However, only three patients had received an initial assessment and EWS within the recommended timeframe of 15 minutes.

EWS audit data supplied by the trust showed variable compliance with staff recording patient early warning scores. We reviewed audit data from the months of June 2017, August 2017 and October 2017. Whilst compliance in June 2017 was 96%, data from August and October was 63% and 85% respectively and was therefore not meeting the monthly target of 95%.

When demand in the department was high, patients awaited ambulance handover in non-treatment areas. The area was visible to clinicians and regularly overseen by clinical staff. To mitigate risk, the department employed paramedics and technicians to regularly review patients waiting for initial assessment for signs of deterioration. During our inspection, we saw that staff were assigned to this role and actively checked patients waiting for assessment for signs of deterioration. This meant that clinical deterioration could be identified and escalated in a timely manner. Emergency buzzers were located in close proximity to this area to enable staff to call for help if required.

All staff within the paediatric emergency department were registered children nurses (RCNs). This meant there was always a paediatric-trained nurse available.

The children’s ED used a paediatric early warning score (PEWS). We reviewed five sets of medical records and saw that a PEWS score was documented on arrival in all records.

The high dependency room within the paediatric emergency department contained advanced paediatric life support guidelines and paediatric intensive care (PICU) retrieval service information for use in an emergency.

The emergency department had a dedicated mental health assessment room for patients with mental health illness. The room had direct oversight from the nurse’s station within the majors area of the adult ED. The risk of blind spots was mitigated with the use of a mirror to facilitate viewing dependent on which window was used. The room was minimally furnished, had suitably weighted chairs, well-lit and provided two points of access with one door opening outwards to prevent the risk of a patient barricading themselves into the room. We identified a potential
ligature point in the mental health assessment room. We escalated our concerns to the Matron who took immediate action to remove this risk by adaptation from the estates department.

Staff had access to ligature cutters in the immediate vicinity of the mental health assessment room. We asked a member of staff to show us where the ligature cutters were located. They were able to demonstrate where they were located and how to use this piece of equipment.

Staff had access to a sepsis policy and pathway within the department. We reviewed the policy and found it to be in date. For guidance, departmental paperwork contained a sepsis tool to ensure that staff identified patients with sepsis in a timely manner. In addition, the emergency department had a sepsis link nurse to provide guidance and information for staff.

The department had a named lead for sepsis. The department had additional support from the critical care outreach team (CCOT). The CCOT had recently conducted a sepsis audit focusing on compliance with the sepsis pathway in place. Results showed that from June 2017 to November 2017, compliance to the pathway ranged between 68% and 77%. Audits were taking place on a monthly basis in the aim to improve compliance.

Staff attended specific sepsis training. Data showed that 74% of staff had received training in sepsis. Training focused on the taking of blood cultures and administration of antibiotics in a timely manner. At the time of our inspection, the department were awaiting installation of a blood culture machine in the resuscitation room.

We reviewed two sets of medical records for patients with known or suspected sepsis. Records demonstrated that one patient had received antibiotics within an hour or arrival in the department and treatment followed that described in the sepsis pathway. However, the second set of records did not have a completed sepsis tool assessment.

Patients at risk of neutropenic sepsis were provided with alert cards to present on arrival to the emergency department. This demonstrated staff started treatment in a timely manner.

Staff received ALERT (Acute Life threatening Events - Recognition and Treatment) training. This training formed part of preceptorship training for newly qualified nurses. This training was aimed to inform staff on how to anticipate, recognise, and improve the quality of care for critically ill patients.

The department had a completion rate of 91% for immediate life support training. We requested data to how compliance with advanced life support training however this was not provided by the Trust.

The department had a completion rate of 93% for paediatric immediate life support training for staff working specifically in the paediatric department.

Staff had access to a transfer kit for use in patient transfer to another hospital or department. We noted the equipment had been checked on a weekly basis and was sealed, ensuring the integrity of contents.

The department used an escalation policy to initiate a response from the site management team during periods of high patient demand. Escalation procedures were determined by a number of factors including patient acuity (how clinically unwell as patient was), numbers of patients within the department and ambulances that were delayed in handover. Senior staff described escalation processes that were in line with policy.

During our inspection, the senior management team were assisting staff to manage flow in the emergency department. Regular updates were provided to the site team throughout the day that resulted in effective oversight of the department. In addition, regular communication took place.
between the local NHS ambulance trust and the service to advise of pressures the department was experiencing.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for the entire 12-month period from October 2016 to September 2017.

Performance against this standard showed an overall trend of improvement, though in January 2017 there was the highest time to treatment with 93 minutes. This was 36 minutes longer than the England average.

In September 2017, the trust performance was 74 minutes compared to the England average of 54 minutes.

**Ambulance – Time to treatment from October 2016 to September 2017 at The Princess Alexandra Hospital NHS Trust**

![Graph showing median time from arrival to treatment](Source: NHS Digital - A&E quality indicators)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median over the entire 13-month period from October 2016 to September 2017.

Performance against this standard showed an overall trend of improvement, and January 2017 showed performance at its highest with time to initial assessment at 33 minutes, compared to the England average of seven minutes. From March 2017 to September 2017 performance remained steady with times ranging between 13 and 17 minutes.

During our inspection, we reviewed data showing arrival to initial assessment times for all patients that presented to the emergency department (self-presenting and arrival by ambulance). Data showed that from 1 October 2017 to 19 December 2017, 49% to 55% of patients received an initial assessment within 15 minutes. The average time from arrival to assessment was 23 to 29 minutes for patients arriving by ambulance. Therefore, the trust was failing to meet The Royal College of Emergency Medicine guidance for rapid assessment and treatment.
Ambulance – Time to initial assessment from October 2016 and September 2017 at The Princess Alexandra Hospital NHS Trust

![Graph showing ambulance time to initial assessment](Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

From November 2016 to October 2017, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at The Princess Alexandra Hospital.

In the latest month October 2017, performance showed 75% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - The Princess Alexandra Hospital**

![Bar chart showing ambulance journeys with turnaround times over 30 minutes](Source: National Ambulance Information Group)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - The Princess Alexandra Hospital**

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

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. From August 2016 to July 2017, the trust reported 1,803 “black breaches”. Performance declined from August 2016 to February 2017, reaching 225 black breaches that month. The trust showed improvement from March 2017 to July 2017 with breaches ranging between 60 and 106.
During our inspection, we found that the numbers and skill mix of staff was suitable for the needs of the emergency department. Senior staff allocated nurses between various clinical areas dependent on demand and patient acuity. Senior departmental staff maintained oversight of staffing within the emergency department. The department used an information board to show the number of nursing staff on duty, and their allocated area of deployment.

During our inspection, we saw that there were two staff based within the resuscitation room to meet the needs of patients. This was an improvement in comparison to our previous inspection.

Nursing handovers took place and staff discussed individual patient needs, plans of care and flow through the department.

At the time of our inspection, the trust had appointment a new head of nursing and this post was due to start approximately one month following our inspection.

Training records for agency nurses included oversight of mandatory training and intravenous (IV) competencies, checked and overseen prior to commencement of work within the department.

The paediatric emergency department had a senior nurse available at all times. All nurses within this area were registered children’s nurses and overseen by a lead nurse.

Following a re-design, the paediatric emergency department had recently changed from being open 16 hours a day to 24 hours a day, seven days a week. At the time of our inspection, the department was using agency and bank staff to meet departmental demand. A skill mix review was due to take place following our inspection.

Vacancy rates

Nurse staffing vacancy rates were high and therefore the department relied on bank and agency staff to fill shifts. The trust recognised nurse vacancy rates as a key issue for the department. The
trust was actively recruiting nursing staff at the time of our inspection and using bank and agency staff to fill shifts.

As of 30 November 2017, nurse vacancy rates within the department were as follows: 66% for Matron band eight nurses, 37% for band seven nurses, 40% for band five nurses, and 21% for band six nurses. This was more than at our previous inspection but the use of agency and bank staff ensured that there were sufficient staff on duty to mitigate the risks to patients.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at July 2017, the trust reported a turnover rate of 1.5% in urgent and emergency care:

- A&E division: monthly average turnover rate of 1.6%
- EAU division: monthly average turnover rate of 1.3%

*Source: Routine Provider Information Request (RPIR) P18 Turnover*

**Sickness rates**

As at July 2017, the trust reported a sickness rate of 3.3% in urgent and emergency care, which is lower than the trust target of 3.5%

*Source: Routine Provider Information Request (RPIR) P19 Sickness*

**Bank and agency staff usage**

The trust reported their shifts filled by agency staff in emergency care from August 2016 to July 2017 below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Reporting Unit</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Nursing</td>
<td>Nursing Assistant</td>
<td>24.53%</td>
<td>22.76%</td>
<td>20.23%</td>
<td>14.42%</td>
<td>21.50%</td>
<td>31.11%</td>
<td>20.99%</td>
<td>13.91%</td>
<td>7.59%</td>
<td>17.96%</td>
<td>23.77%</td>
<td>19.98%</td>
</tr>
<tr>
<td>A&amp;E Nursing</td>
<td>Qualified Nurse</td>
<td>48.08%</td>
<td>44.84%</td>
<td>58.39%</td>
<td>49.88%</td>
<td>49.52%</td>
<td>54.68%</td>
<td>54.32%</td>
<td>63.31%</td>
<td>53.12%</td>
<td>60.55%</td>
<td>57.27%</td>
<td>67.03%</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>Nursing Assistant</td>
<td>22.76%</td>
<td>19.73%</td>
<td>19.22%</td>
<td>14.16%</td>
<td>11.38%</td>
<td>17.70%</td>
<td>17.20%</td>
<td>17.45%</td>
<td>23.52%</td>
<td>17.96%</td>
<td>15.68%</td>
<td>14.92%</td>
</tr>
</tbody>
</table>

A&E nursing showed the most agency usage throughout the entire reporting period with the latest months June 2017 and July 2017 having 67% of shifts being filled.

*Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency*

Agency nurses received an induction prior to starting work in the department. The induction process included intravenous (IV) training, various competencies, safeguarding and computer system training.
Medical staffing

Consultant cover was provided in the adult emergency department between the hours of 8am to 12am. The presence of 16-hour consultant cover was in-line with The College of Emergency Medicine Workforce recommendations.

Outside of these hours, consultant cover was provided on an on-call basis to ensure junior doctors were supported.

The paediatric emergency department had a rota in place for consultant cover between 8.30am to 9.30pm. Outside of these hours, on-call consultant paediatrician cover was available. A registrar was based in the paediatric ED between the hours of 9am to 9pm. There was access to paediatric registrar and senior house officer 24 hours a day, seven days a week. This meant the department was working in line with The Royal College of Emergency Medicine guidance on medical staffing.

Comprehensive handovers took place, engaging all grades of medical staff. Regular board rounds took place throughout shifts to ensure that staff shared patient information appropriately.

Vacancy rates

The emergency department (ED) consisted of 12 whole time equivalent (WTE) consultant posts. Data requested following our inspection showed a vacancy rate of 33% for consultants, 50% for foundation year 2 doctors, 43% for speciality doctors and 4% for speciality registrar grade. However, staff we spoke with did not raise any concerns regarding medical cover or the ability to meet patient needs.

Turnover rates

As at July 2017, the trust reported a turnover rate of 1.5% in urgent and emergency care:

- A&E division: monthly average turnover rate of 1.9%
- EAU division: monthly average turnover rate of 1.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

As at July 2017, the trust reported a sickness rate of 1% in urgent and emergency care, which was lower than the trust target of 3.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From 1 August 2016 to 31 July 2017, the rate of agency medical locum usage, by shift, was as follows:

- 408 consultant grade shifts
- 1,328 doctor in training grade shifts
- 1,238 middle grade shifts
Staffing skill mix

From August 2017 to August 2017, the proportion of consultant staff reported to be working at the trust and the proportion of junior (foundation year 1-2) staff were both lower than the England average.

Staffing skill mix for the 59 whole time equivalent medical staff working in Urgent and Emergency Care at The Princess Alexandra Hospital NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>49%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff did not always keep appropriate records of patient’s care and treatment. This meant that staff did not always complete records in a way that promoted patients safety and wellbeing.

Paper based patient records in the majors area of the emergency department were held in transportable notes trolleys at the nurses’ station. Staff did not lock the trolleys, as they required immediate access to the records at all times. A member of trust staff could see the patient notes at all times. This meant there was minimal risk of unauthorised people accessing patient’s medical records to protect patients’ confidential medical records.

The electronic patient information board in the adult emergency department protected the confidentiality of patients by displaying only the surname.

Medical records contained information on any complex or additional needs a patient had.

Patient’s care and treatment records were a combination of electronic and paper based format. Staff documented the initial assessment of patients presenting to the rapid assessment and triage (RAT) area electronically, whilst further medical and nursing staff recorded further notes and assessments in a paper format. This was an emergency department specific document, which included specific risk assessment documents such as infection control, pressure ulcers, nutrition and hydration and falls. This document also included assessment charts to enable physiological observations such as blood pressure, heart rate, respiratory rate, and temperature to be recorded. There was also a fluid balance chart and an hourly comfort-rounding tool as well as a section for
recording the care provided for patients in addition to the transfer and discharge of patients. Doctors had a separate clerking sheet, which included a page for prescribing medications and intravenous fluids.

During our inspection, we reviewed 21 sets of adult and six sets of paediatric patient records. Of these records, seven sets were for patients who had presented to the department with a mental health concern or condition.

At our previous inspection in June 2016, we found that medical and nursing records were accurate and completed with documentation of appropriate risk assessments, pain relief and early warning scores (NEWS). At this inspection, we found variations in the accuracy and completeness of patient records. Staff did not always complete individual patient risk assessments within appropriate timescales, for example, seven out of 21 sets of records did not have a pressure ulcer risk assessment.

At our announced inspection in December 2017, we found that risk assessments such as the Anderson pressure ulcer risk assessment were not completed, or was inaccurately completed, as staff did not have immediate access to the risk assessment tool. If patients scored more than two on their Anderson risk assessment, nursing staff should have completed another nationally recognised pressure ulcer assessment known as a Waterlow risk assessment. This meant patients could be placed at increased risk of developing pressure ulcers because the appropriate risk assessment had not been completed.

We raised our concerns about the completeness of risk assessment records with senior staff in the emergency department and with the trust’s senior leadership team who told us they would look into our concerns. They also provided assurance that the trolleys in the emergency department had pressure-relieving properties as the mattresses were of a high specification.

At our unannounced inspection on 17 December 2017, we looked at three sets of records and found an improvement in the recording of pressure ulcer risk assessments. However, in all three sets of records we noted the patients were at high risk of developing pressure ulcers but there was no evidence that pressure area care had been undertaken or that hourly intentional comfort rounding had taken place. All patients within the emergency department should receive hourly comfort rounds. Comfort rounding is a scheduled check on each patient’s comfort every hour and to establish if they require anything for example whether patients require repositioning, need the toilet or require something to eat and drink. Again, we raised this with senior staff in the emergency department who agreed that staff had not fully completed the documentation.

We reviewed seven sets of records relating to patients who had accessed the emergency department and who had a mental health concern or condition. We found that mental health risk assessments were appropriately completed and patients referred to mental health services where appropriate. There was no flagging system within the emergency department to alert staff to patients attending with mental health conditions but there was a prompt for staff to assess mental health of patients coming into the department.

Medical records contained appropriate details for patients with mental health, learning disability and dementia needs alongside physical health needs.

Mental health records were shared effectively to avoid unnecessary admissions and demonstrated referral to an appropriate specialist team.

The department carried out a monthly medical records audit looking at nine areas of medical records completeness including pressure ulcers, medicines management and falls standards. Data from April 2017 to October 2017 was incomplete and no data was returned for the months of
April, May, and September 2017. The target for compliance was set at 95% however; the audit demonstrated poor outcomes in relation to nutritional, falls and pressure ulcer standards.

The department audited and monitored the sending of discharge letters. We requested data after our inspection that showed from 13 December 2017 to 19 December 2017 inclusive, the department was required to send 1178 discharge letters relating to episodes of care. Performance was at 60% and the emergency department teams received daily data to ensure that outstanding discharge letters were completed and sent.

Following our inspection the trust’s chief nurse told us a full review of the paperwork used in the emergency department was underway.

**Medicines**

The trust had a medicines management policy in place. Stock was effectively overseen and ordered in conjunction with the trust’s pharmacy team.

Staff securely stored controlled drugs within both the adult and children’s emergency department in wall-mounted cupboards, in line with legislation. We checked a random selection of controlled drugs in both areas and found that documented quantities for medicines, matched actual stock levels. A member of authorised staff from both the paediatric and adult emergency department held the keys to the controlled drugs cupboards to enable timely access to medicines.

Staff stored non-controlled medicines in areas that were restricted by key code access. We found all areas to be well organised and medication was clearly labelled to ensure that staff could locate medicines in a timely manner.

Staff checked each patient’s names, date of birth and allergies prior to the administration of medicines. We reviewed nine medication administration records and noted that all records documented allergies if applicable, or stated ‘no known allergies’ if none had been reported.

The department used patient group directives (PGDs) to ensure that patients had timely access to medicines and treatment for cases of neutropenic sepsis. We reviewed the PGDs and found them to be compliant having all the correct requirements and with appropriate signatures and therefore suitable for use.

The department had a quality indicator dashboard in place, which utilised a red, amber green (RAG) rating to indicate performance in relation to controlled drugs checks in the resuscitation area. Data showed that the department achieved 100% compliance in all month from September 2017 to November 2017.

The trust’s medicines management policy stated that staff must check medication fridge temperatures and document temperatures on a daily basis. We reviewed the check sheets that demonstrated checks had taken place on the five days prior to our inspection. Safe temperature ranges were between two and eight degrees Celsius.

The department used a quality indicator dashboard to monitor compliance with fridge checking procedures. From September 2017 to November 2017, compliance for fridge checks in the resuscitation room was 100%, 90%, and 96% respectively. For the same period, the antidote fridge, located in the department, achieved 100%, 87%, and 96% respectively.

The fridges in the majors area and resuscitation room had exceeded the maximum temperature on four out of five days. Policy and local guidance stated that if a fridge exceeded the recommended temperature, escalation to pharmacy team was indicated to check and ensure the integrity of medicines contained within this area. No escalation had taken place.
We raised our concerns with the Matron who undertook an immediate review of medicines held within this area in conjunction with the pharmacy team. In addition, micro training sessions were being introduced to ensure staff were competent in the process of medication fridge temperature checking.

**Incidents**

There were clear incident reporting processes in place. Staff understood their responsibilities to raise concerns and report incidents. Members of staff we spoke with were able to tell us how incidents were reported and that information was shared with staff so they could learn from previous incidents.

Staff reported incidents on the trust’s electronic online reporting system. Staff had access to computer terminals to enable the timely reporting of incidents.

The matron for the emergency department had oversight of all incidents that were reported. Staff attended daily ‘safety huddles’ to share information on incidents in a timely manner amongst staff.

Senior nursing staff had a daily huddle with the patient safety and quality group to discuss and share information arising from reported incidents. Staff we spoke with confirmed that huddles took place on a daily basis. Serious incident group (SIG) meetings took place on a daily basis. The purpose of these meetings was to discuss and act upon incidents and the use of the duty of candour.

Staff room areas contained folders showing investigation outcomes and learning from incidents to prevent recurrence.

Incident feedback and learning was shared through a weekly email to all staff.

We reviewed two investigation reports following serious incidents within the department. Both investigations contained a root cause analysis of each incident, lessons learnt and methods for sharing learning amongst relevant staff. In addition, we reviewed that action plans in relation to each incident that had been completed.

The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and offer reasonable support to the person. All staff we were aware of the duty of candour.

Both investigations demonstrated use of the duty of candour. A duty of candour lead had been appointed to liaise with the patient and family in both investigations that we reviewed.

The emergency department held bi-monthly mortality and morbidity meetings and staff of various grades were encouraged to attend mortality and morbidity meetings. Our review of meeting minutes from July 2017, September 2017 and November 2017 showed that regular discussion had taken place around presentations of various clinical cases with related recommended changes in practice in response to any concerns. For example, the introduction of measures to improve communication between teams and raising awareness of antibiotic guidance within the emergency department.

The department had an emergency planning and resilience lead in post that assisted in the delivery of one day training for staff in major incident preparedness. At the time of our inspection, 97% of staff within the department had completed this training. Regular communication took place with the lead and other local organisations to discuss major incident priorities; for example the threat of terrorism, air crash, or information technology failure.
The emergency department had access to a major incident store, which contained equipment in the event of a declared major incident or chemical, biological, radiological and nuclear (CBRN) attack. This area contained appropriate equipment including but not limited to; personal protective equipment, tents and radios.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2016 to September 2017, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement - STEIS)*

### Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England from October 2016 to September 2017.

All three incidents occurred within February 2017. Two were categorised as treatment delays meeting the serious incident criteria, the other was recorded as a diagnostic incident.

*(Source: NHS Improvement - STEIS)*

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported zero new pressure ulcers, one fall with harm and two new catheter urinary tract infections from October 2016 to October 2017 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Princess Alexandra Hospital NHS Trust**

<table>
<thead>
<tr>
<th>Total pressure ulcers (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
</tr>
<tr>
<td>0.8</td>
</tr>
<tr>
<td>0.6</td>
</tr>
<tr>
<td>0.4</td>
</tr>
<tr>
<td>0.2</td>
</tr>
<tr>
<td>0.0</td>
</tr>
</tbody>
</table>
Is the service effective?

Evidence-based care and treatment

The department provided care, which was evidence based and in line with national guidance, such as the national Institute for Health and Care Excellence (NICE) and the Royal College of Emergency medicine (RCEM standards. This was an improvement since our previous inspection.

Trust policies and procedures were available to view electronically. Staff we spoke with knew how to locate policies and procedures.

There were specific pathways demonstrating adherence to national guidance including sepsis and fractured neck of femur amongst others.

We reviewed adult advanced life support algorithms and based on relevant guidelines produced by the Resuscitation Council (UK). Guidance for massive blood loss referred to the National Institute for Health and Care Excellence (NICE) guidance.

We reviewed two sets of patient medical records in relation to patients with known or suspected sepsis. One set demonstrated a patient with sepsis had received appropriate treatment including completion of the sepsis tool, antibiotics, monitoring, and referral to the medical team. The second set of medical records showed that the sepsis tool had not been completed. We raised our concerns with the Matron who stated this should have been completed and that they would review the medical record in detail and provide feedback to staff.

The department participated in the Royal College of Emergency Medicine (RCEM) audits. In addition, the department worked cohesively with the critical care outreach team in performing sepsis compliance audits.

The emergency department collected data for the Commissioning for Quality and Innovation (CQUIN) scheme, which is intended to deliver clinical quality improvements and drive transformational change. Data was collected to improve the timely recognition and treatment of patients with serious infections such as sepsis.

Data from March 2017 to May 2017 showed that compliance with intravenous antibiotic administration took place in 90%-92% of cases. For the same period, 74%-88% of cases achieved...
compliance with the ‘sepsis six’ bundle, which is a set of medical treatments designed to reduce the mortality of patients with sepsis. This was an improvement since our previous inspection.

**Nutrition and hydration**

Domestic staff offered patients hot and cold drinks throughout their stay in the emergency department where it was clinically safe to do so. In addition, sandwiches were available in the department throughout the day and out of hours.

Nursing staff had visual prompts on the newly implemented patient safety checklist to offer refreshments at hourly intervals. However, the checklist was not routinely completed due to its recent introduction and pressures on staff within the department. Our review of medical records demonstrated that the safety checklist was not being regularly used. Therefore, we could not gain assurances that the nutritional and hydration needs of patients were being effectively assessed.

We spoke with three patients on their experience of refreshments offered during their time in the department. Two patients stated that they had been offered food and drink at regular intervals. However, one patient we spoke with told us that there had been a lack of refreshments offered overnight due to high demand within the department. In addition, relatives fed back that there were no facilities, outside the trusts canteen and cafe opening hours to buy additional food or drink.

Visitors to the department had access to fresh drinking water in waiting areas. In addition, there were hot drink making facilities in the relatives room, adjacent to the resuscitation area.

The emergency department had recently been refurbished and vending machines had been temporarily removed, and we noted throughout our inspection, there were limited options for the provision of food and hot drinks for relatives and carers that visited the department. However, visitors and all patients booking into the emergency department were given information by reception staff on raising concerns and how to ask for food and drinks, which were provided free of charge, 24 hours a day. Vending machines were also located a short distance from the emergency department in an adjacent part of the building.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.4 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Pain relief**

The department assessed and recorded a pain score for patients arriving in the department as part of their initial assessment in line with the Faculty of Pain Medicines Core Standards for Pain Management.

The newly implemented patient safety checklist prompted staff to reassess pain at hourly intervals. However, due to recent implementation, this checklist was not always completed.

The department used pictorial charts for patients that were unable to verbalise that they were in pain.

We spoke with three patients who told us their pain was being adequately managed and that pain relief had been administered in a timely manner. We reviewed nine sets of medication.
administration records which demonstrated appropriate analgesia had been prescribed and administered in a timely manner where clinically indicated.

We reviewed five medical records for children that presented to the paediatric emergency department. We saw that pain had been assessed and documented upon arrival in the department and triage. This was in line with the Royal College of Emergency Medicines guidance on the management of pain in children.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.0 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey - September 2016)*

**Patient outcomes**


**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute Severe Asthma report, the trust was in the upper UK quartile for none of the standards.

The trust was in the lower UK quartile for one standard:

- Standard 2a: Vital signs should be measured and recorded on arrival in ED – 12%

The trust’s results for the remaining six standards were all between the upper and lower UK quartiles.

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. Trust: 14%, UK: 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 14%, UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 77.3%, UK: 77%.
- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone
• Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Trust: 26.3%, UK: 19%.
• Standard 5b (fundamental): within 4 hours (moderate). Trust: 12.9%, UK: 28%.
• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows: Adults 16 years and over: 40-50mg prednisolone for 5 days, children 6-15 years: 30-40mg prednisolone for 3 days, children 2-5 years: 20mg prednisolone for 3 days. Trust: 45.7%, UK: 52%.

(Source: Royal College of Emergency Medicine)

In response to the RCEM Moderate and Acute Severe Asthma 2016/17 audit results, the department had developed an action plan. We reviewed the plan, which demonstrated actions related to all patients being reviewed by a respiratory clinical nurse specialist and the development of a local asthma multidisciplinary team.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the trust met all of the standards.

The trust was in the upper UK quartile for no standards:

The trust was in the lower UK quartile for no standards:

The trust’s results for all four standards were all between the upper and lower UK quartiles.

Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 9.8%, England: 11%.

Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Trust: 2.8%, UK: 8%.

Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Trust: 6%, UK: 12%.

Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust: 12%, UK: 10%.

(Source: Royal College of Emergency Medicine)

In response to the RCEM consultant sign off audit results, the department had developed an action plan. We reviewed the action plan, which demonstrated action related to areas of consultant and middle grade recruitment, adaptation to internal computer systems to allow evidencing of senior review taking place and the sharing of audit results with relevant staff.

The department had recently commenced the submission of data to The Trauma Audit and Research Network (TARN). No data was available at the time of our inspection, as participation in this audit had recently commenced.

RCEM Audit: Severe Sepsis and Septic Shock 2016/17
The trust was in the upper UK quartile for no standards:

The trust was in the lower UK quartile for three standards:

The trust’s results for the remaining five standards were between the upper and lower UK quartiles.

Standard 1 (Fundamental): Respiratory rate, oxygen saturations, supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness and capillary blood glucose recorded on arrival 100%. Trust: 26.6%, UK: 69.1%.

Standard 2 (Developmental): Review by senior (ST4+ or equivalent) ED medic or involvement of Critical Care Medic (including outreach team or equivalent) before leaving ED. Trust: 48.4%, UK: 64.6%.

Standard 3 (Aspirational): Oxygen was initiated to maintain oxygen saturations greater than 94% (unless there is a documented reason not to): 50% within one hour. Trust: 12.9%, UK: 30.4%.

Standard 4 (Aspirational): Serum lactate measured: 50% within one hour of arrival. Trust: 54.7%, UK: 60%.

Standard 5 (Aspirational): Blood cultures obtained: 50% within one hour of arrival. Trust 17.5%. UK 44.9%

Standard 6 (Aspirational): Fluids – first intravenous crystalloid fluid bolus (up to 30mL/Kg) given: 75% within one hour of arrival. Trust 50%. UK 43.2%.

Standard 7 (Aspirational): Antibiotics administered: 50% within one hour of arrival. Trust 45.3%. UK 44.4%

Standard 8 (Developmental): Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust 17.2%. UK 18.4%.

(Source: Royal College of Emergency Medicine)

The emergency department had a named doctor who was responsible for the oversight and submission of data in relation to the RCEM Sepsis audit.

The critical outreach team (CCOT) had recently conducted a sepsis audit focusing on compliance with the sepsis pathway in place. Results showed that from June 2017 to November 2017, compliance to the pathway ranged between 68% and 77%. Audits were taking place on a monthly basis with the aim of improving compliance.

Unplanned re-attendance rate within 7 days

From October 2016 and September 2017, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally better than the England average. In the latest period, September 2017 the trust performance was 7% compared to the England average of 7.7%. This was an improvement since our previous inspection.
Competent staff

Appraisal rates

As of August 2017, 87% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. There was some improvement since our previous inspection in that only 76% of staff had had an appraisal in 2016.

A split by and reporting unit can be seen in the graph below:

Nursing & midwifery staff within the A&E nursing department failed to meet the trust target of 90% for appraisals with a 77% completion rate. The trust met and exceeded the target for the remaining four reporting units within A&E.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The department had assessed the learning needs of staff by means of appraisal.

The department had a dedicated practice development nurse to provide support in the development and education of staff. During our inspection, we saw the practice development
nurse was accessible to staff and located within the adult emergency department. We requested up to date appraisal compliance data following our inspection. This showed that 100% of medical staff and 86% of nurses had received an appraisal.

Staff we spoke with told us the appraisal process was meaningful.

The department maintained oversight of when nurses were due to revalidate with the Nursing and Midwifery Council. At the time of our inspection, all 39 nurses in the department were up to date with revalidation. Records demonstrated clear oversight of when future revalidation was due, with a member of staff checking personal identification numbers (PINs) on a monthly basis.

Medical staff revalidation was overseen on a monthly basis by the trust wide Medical Appraisal and Revalidation Committee (MARC). Staff had access to policies relating to revalidation for guidance.

The department had a comprehensive programme for the delivery of training for nursing and medical staff. Non-mandatory training included but was not limited to; conflict resolution, Mental Capacity Act and Deprivation of Liberty training.

Each member of nursing staff had a named mentor. This enabled staff to identify and raise any training needs they had. We saw mentor information was displayed in staff restroom areas. Staff had access to their mentor and two protected training days per year. This was an improvement since our previous inspection.

The department had trained specialists in subjects including, but not limited to; learning disability, dementia, sepsis, mouth care and early pregnancy loss. This meant had received appropriate training to enable them to carry out their role.

The emergency department provided training in conflict resolution. Data submitted by the trust demonstrated showed 89% of staff from the emergency department had received this training. In addition, 100% of staff had received training in dementia awareness and 100% had received training in learning disabilities.

Staff had protected ‘away days’ which took place once every six months. This provided protected time for training and covered a variety of subjects from mandatory training.

All nursing staff working in the paediatric emergency department were registered children nurses (RCNs).

We spoke with one agency nurse who told us that they had received an induction prior to starting work in the department. Staff told us induction included intravenous (IV) training, various competencies, safeguarding and computer system training.

Locum doctors completed an induction pack prior to starting work in the department. Induction included access to computer systems, departmental values, and provided all locum staff with contact details for key people such as safeguarding and learning disability nurses.

We spoke with two junior doctors who told us they felt supported in their role explaining there were always opportunities to learn and develop.

Staff of all grades were encouraged to attend bi-monthly mortality and morbidity meetings and to participate in local audit programmes.
**Multidisciplinary working**

Staff demonstrated effective multidisciplinary team working. We saw that communication took place between a range of healthcare professionals to improve patient care and outcomes.

The department was in the process of compiling standardised letters to GPs within the area to improve referral pathways to the department.

During our inspection, we observed a handover from an air ambulance crew who had bought a patient in to the emergency department as an alert call. The emergency department had a medical team waiting for the crews arrival to ensure the immediate assessment and treatment of a critically unwell patient. We observed effective communication taking place between staff.

The department was undergoing a process of redesign throughout our inspection. The trust had plans for specific office space in the department for specialist teams such as alcohol liaison, paediatric mental health, adult and mental health to ensure effective cross-team working and communication.

The paediatric emergency department maintained good working relationships with the children’s wards and staff communicated well with each other from both the adult and paediatric emergency department. Joint team working occurred when critically unwell paediatrics were bought in to the adult emergency department resuscitation room.

The critical care outreach team (CCOT) regularly visited the department. Staff from the CCOT routinely worked in the adult emergency department’s resuscitation room to improve and build upon communication with both teams.

The emergency department had access to a frailty team. The service was established in November 2016 to improve the outcomes for patients and reduce the length of stay in hospital, using comprehensive geriatric assessments and timely discharge if appropriate. The frailty team was working in conjunction with the short stay unit and dementia champions to improve care for this group of patients.

Mental Health liaison meetings took place on a regular basis with multi-agency input from alcohol liaison teams, local inpatient mental health service staff and dementia support staff.

All staff we spoke with were clear in reporting processes to local services such as substance misuse and alcohol liaison services.

We spoke with a physiotherapist who described close links with the frailty team and described that regular communication between teams’ improved patient outcomes and safety within the department.

**Seven-day services**

The adult and paediatric emergency department at The Princess Alexandra Hospital was open 24 hours a day, seven days a week in line with the NHS seven days a week Priority Clinical Standard six.

The emergency department had consultant presence between the hours of 8am and midnight, with on-call cover outside of these times.

The paediatric emergency department had a rota in place for consultant cover between the hours of 8.30am to 9.30pm. Outside of these hours, consultant cover was on an on-call basis.
The department had access to a range of imaging services. X-ray, magnetic resonance imaging (MRI) and computerised tomography (CT) scanners were available 24 hours a day, seven days a week, facilitated by a team of radiographers. An outside provider interpreted results and fed back to staff within indicated timeframes.

NHS England’s seven day services priority standard number two, states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. We requested data to reflect the time of arrival to speciality review that had taken place in the emergency department. For the month October 2017, 12% of patients were seen in under one hour, 19% within one to two hours, 17% in two to three hours, 17% in three to four hours and 33% of patients waited over four hours. Figures for November 2017 and December 2017 were similar to the previous month.

Hospital chaplaincy services were available 24 hours a day, seven days a week.

An alcohol liaison nurse was available Monday to Friday 9am to 5pm.

The trust provided mental health nurse cover was provided 24 hours a day, seven days a week for adults.

Learning disability support nurses were available Monday to Friday, 9am to 5pm. Outside of these hours; staff flagged patients to the site team for the nurse specialist to review the following day.

The frailty assessment team were available between the hours of 9am to 5pm, Monday to Friday.

Staff had access to the community assessment and reablement team (CARS) nurses between the hours of 8am and 6pm, seven days a week.

Health promotion

Staff provided information to patients on how to manage their condition and promote a healthy lifestyle.

Information around diet and health was available on the hospital’s public website. Information included dietary advice, aspects of healthy living, diabetes and children’s health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy named ‘Mental Capacity’. The policy was in date and based on relevant legislation. It provided clear guidance for staff and cross referred to trust policies on Deprivation of Liberty Safeguards, consent, and safeguarding.

The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for their self. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. DoLS aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

The department provided Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of safeguarding training. Members of the safeguarding team were available to provide advice and guidance relating to MCA and DoLS.
Dementia and learning disability speciality nurses were available to offer advice and guidance on the MCA and DoLS if required.

There was a policy in place to provide guidance to staff for patients detained under Section 136 of the mental Health Act, including the assessment of capacity.

Staff we spoke with understood their responsibilities in relation to the MCA and DoLS.

Staff did not consistently record whether consent had been obtained. We reviewed nine sets of medical records to establish whether staff took and recorded patient consent. Out of five applicable records, staff had recorded consent in one record. Therefore, we were not assured that consent was being appropriately assessed and recorded.

During our inspection, we observed that staff verbally asked for patient consent when performing examinations and treatments such as blood pressure monitoring and taking blood.

The trust had a policy named ‘Consent to Examination or Treatment Policy and Guideline’. This documented was in date, based on relevant legislation and clearly referenced consent taking procedures for children under the age of 16 years and the Gillick competence.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was generally better than the England average throughout the reporting period aside from a three month decrease in performance from January 2017 to March 2017 where the trust was below the average.

In September 2017 the trust performance for those who would recommend was 91.9%.

**A&E Friends and Family Test Performance - The Princess Alexandra Hospital NHS Trust**

(Source: NHS England Friends and Family Test)
Throughout our inspection, we observed staff offering patients compassionate care at all times. However, we spoke with one nurse who told us sometimes, there was not enough time to spend with patients and their relatives due to demand within the department.

When the department was under pressure, we saw that call bells sometimes went unanswered for prolonged periods.

The department had introduced a role called ‘ward assistant’ to help provide care for patients within the emergency department. We spoke with a ward assistant who described their role as ensuring that patients were comfortable, offered refreshments at regular intervals and provided with company if needed.

We observed two emergency alert calls for patients who arrived by ambulance. On both occasions, medical staff spoke with patients in a kind and caring manner, and explained what would happen next and what treatments may be required.

Staff ensured the privacy and dignity of patients was maintained with the use of curtains, blankets, and portable screens.

A member of staff within the paediatric emergency department described an episode of compassionate care when caring for a patient with autism. The patient was experiencing sensory difficulty in the department so they went to the cafe instead of carrying out an assessment in the busy department. This demonstrated compassionate care from staff to ensure that the patient was assessed in an area, which caused less distress.

A parent of a patient in the paediatric emergency department described how staff reassured and kept them informed of waiting times, whilst regularly checking their child. Staff within the paediatric emergency department explained treatments and care to patients in a child friendly way.

We spoke with one patient who said staff were “Very caring, friendly and wanted to help”. Another patient said, “I have had brilliant care, you can’t fault the staff, this hospital is great”.

Staff spoke with patients in a reassuring manner and offered information on waiting times on a regular basis.

**Emotional support**

Staff emotionally supported patients and relatives who were distressed or upset providing kind words and reassurance.

Hospital chaplaincy services were available at all times. Multi-faith support was available through the hospital chaplaincy team to provide emotional and spiritual support on request.

We saw staff in the paediatric emergency department supporting patients and their relatives emotionally. We saw staff listening to patients and responding in a kind and caring manner.

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

Where possible staff involved patients and their relatives in decisions about care and treatment.

We spoke with patients and relatives of paediatric patients who all told us staff had explained treatments and care in a way that their child could understand.

We spoke with two patients who told us they were kept updated about their condition, treatment plans, and prognosis.
We saw that staff spoke with patients and their relatives. One example was when staff discussed a patients care and treatment with a family member to ensure that the discharge could be coordinated effectively due to change in mobility needs.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in two of the 24 questions relevant to caring. The trust scored about the same as others for the remaining 22 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>2.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
| Q45. Overall (please circle a number)                                   | 7.4        | Worse than other trusts    

(Source: Emergency Department Survey - September 2016)
Is the service responsive?

Service delivery to meet the needs of local people

Since our last inspection in June 2016, the emergency department had undergone a reconfiguration to ensure the environment was fit for purpose and to assist with demand and flow through the department. The facilities and premises were appropriate for the service that was being delivered. The waiting area had been designed with adequate seating and patients were offered a chair to use when booking in to the department.

The department was meeting the Royal College of Emergency Medicine (RCEM) Quality Standards one, three, five, six and ten. All areas of the department were clean, well lit, and in good working order. Reading material was available in the waiting areas and waiting time information was displayed. Signage and information in the department was clear which enabled patients and visitors to navigate the department.

The service worked in partnership with local clinical commissioning groups (CCG’s), local ambulance trusts and NHS Improvement to plan and ensure the service was meeting the needs of local people.

The service recognised that demand and flow throughout the department was a key issue. The adult emergency department had recently introduced a new rapid assessment and treatment (RAT) area to improve flow and reduce the time to initial assessment for patients arriving in the department.

The department had introduced two GPs to reduce pressure on the emergency department and worked with local GPs to ensure appropriate pathways were followed to avoid unnecessary admissions.

Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored “about the same” as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey - September 2016)

The service was meeting and identifying the communication needs of patients with a disability or sensory loss. Medical records were flagged to indicate if a patient had additional or complex needs to ensure that staff responded appropriately.

Staff told us about if a patient with learning difficulties presented to the emergency department. This allowed the learning disability nurse to review medical records and attend to support the
patient if required. Staff encouraged relatives and carers to stay with patients who had learning difficulties to ensure that the patient had a familiar person accompanying them wherever possible.

The department had access to translation services for patients whose first language was not English. Information leaflets were available in alternative languages upon request.

The department had a room to provide a peaceful environment for the families and friends of patients that were critically ill, or recently bereaved. The room provided comfortable seating, and facilities to make hot drinks.

The department had access to a hospital chaplain. Multi-faith support was available to meet patient’s individual needs.

The department had been re-designed to make use of dementia friendly colour schemes and flooring. Plans for the future included the implementation of a sensory room, which was due for completion following our inspection.

Staff described making ‘distraction packs’ from various items to provide distraction for patients with dementia or learning disabilities. Twiddle muffs were available to provide stimulus for patients with dementia and dementia nurse specialist advice was available upon request.

The department had a dedicated room for patients who were deceased. This provided relatives with a quiet and private space to view their loved ones.

The department had two rooms to accommodate relatives and carers of acutely unwell patients. The rooms were located adjacent to the resuscitation room and provided a quiet space with comfortable seating to accommodate families and carers in times of emotional distress.

Each cubicle within the resuscitation area contained a communication book and information to assist in the care of patients with complex needs. The book contained pictorial pain charts, symbol charts, Makaton signs and other useful information.

On four occasions during our inspection, we saw that call bells were not answered for more than five minutes. We witnessed one patient who was visibly distressed which we escalated to a senior member of staff within the department. Whilst they responded immediately, we could not gain assurances that staff met patients’ needs in a timely manner during busy periods.

The paediatric emergency department had access to play specialists, located in the children and young people’s department at the hospital. This enabled specialist staff to assist patients in the use of distraction techniques and play.

The children’s ED had a dedicated waiting area, which had been thoughtfully designed with young people in mind. This included the use of colourful wall art. This area contained appropriate toys for young patients. This waiting room was overseen by nursing and reception staff who were based in this area. At the time of our inspection, the department had recently opened and was awaiting installation of a DVD player to provide distraction for visiting young people.

The paediatric emergency department had introduced puzzle books and activity packs for older children, to help reduce anxiety when they visited.

This paediatric emergency department was colourfully decorated to appeal to children of various ages.

There was a variety of leaflets and information in the main emergency department waiting area for patients and visitors, including advice on minor injuries, antibiotics treatment and various ailments. In addition, there was information on how to access GP services. Patients were kept up to date with information buy use of a patient information television.
Patients waiting in the emergency nurse practitioners area had access to various leaflets providing information and guidance on a range of minor injuries.

**Access and flow**

There were systems in place to manage the flow of patients through the department. Length of stay was colour coded using a computerised red, amber and green (RAG) system to inform staff when patients were near to end of the four-hour waiting target. This was displayed in prominent areas of the department to ensure staff had oversight of current waiting times and delays. The site management team also maintained oversight of this system, in conjunction with flow throughout the hospital.

Regular bed management and site team meetings took place throughout the day to assess demand and the status of the department to try to maintain and improve flow in the emergency department.

In November 2017, the trust introduced the post of service manager to assist with flow in the department. This post was to provide support in the department, assist in the minors department and contact various specialities in response to patients in the department. In addition, the role assisted with the escalation of high demand in the department to the trust’s site management team.

During our inspection, we observed this role in practice. High demand in the department was effectively escalated and there was support in place from the site management and senior management team during these periods.

The department internally monitored arrival to initial assessment times for patients that self-presented to the department.

The department closely monitored performance against the four-hour target on a regular basis. For the week leading up to our inspection, performance ranged between 58% and 79%. However, 79% was an improvement on the previous inspection held during summer of 2016. During our inspection, the clinical decisions unit (CDU) and surgical assessment unit (SAU) was closed due to the reconfiguration. This therefore affected patient’s timely departure to these areas from the department. Both areas were due to open within a week of our inspection. In addition, the hospital was experiencing high demand for beds, meaning space on wards was limited.

Access and flow throughout the department were recognised as key challenges by the clinical lead, matron and senior management staff along with the trust wide management team.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department (ED).

The trust failed to meet this standard across the whole of the 12-month period from November 2016 to October 2017. The trust breached the standard 12 times from November 2016 to October 2017. From November 2016 to October 2017, performance against this metric showed a trend of decline.

In January 2017, trust performance was at its lowest with 63%, there was a slight improvement in
the following months however from June 2017 onwards performance began to decline. The trust was consistently lower than the England average and standard.

The paediatric emergency department provided data indicating how many patients had been admitted, transferred or discharged within four hours of arrival to the paediatric emergency department. Data from June 2017 to December 2017 demonstrated that between 86% to 94% were admitted, transferred or discharged within four hours.

**Four-hour target performance - The Princess Alexandra Hospital NHS Trust**

![Graph showing four-hour target performance](Image)

(Source: NHS England - A&E Waiting times)

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

Between November 2016 to October 2017, The Princess Alexandra Hospital NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average. Although February 2017 saw an improvement in-patient waiting times the general performance against this metric showed a trend of decline over the reporting period.
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - The Princess Alexandra Hospital NHS Trust

![Graph showing percentage of patients waiting between four and 12 hours from the decision to admit until being admitted.](graph)


Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from November 2016 and October 2017, one patient waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting four to 12 hours were in January 2017 with a total of 881.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-16</td>
<td>641</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>667</td>
<td>1</td>
</tr>
<tr>
<td>Jan-17</td>
<td>881</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>763</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>278</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>276</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>469</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>706</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>536</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>556</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>552</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>608</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From October 2016 to September 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was better than the England average, in the latest period September 2017 trust performance was 2% compared to
the England average of 3.1%. Performance for this metric generally followed the trend of the England average.

**Percentage of patient that left the trust without being seen - The Princess Alexandra Hospital NHS Trust**

![Graph showing percentage of patients leaving the trust without being seen](image)

(Source: Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

From October 2016 to September 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Although January 2017 had the highest total time in A&E with 198 minutes against the England average of 154 minutes the overall trend generally mirrored the average throughout the reporting period.

In the latest month September 2017, the total time in A&E was 153 minutes against the England average of 148 minutes.

**Median total time in A&E per patient - The Princess Alexandra Hospital NHS Trust**

![Graph showing median total time in A&E per patient](image)

(Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

From August 2016 to July 2017, there were 32 complaints about urgent and emergency care services. The trust took an average of 57 working days to investigate and close complaints, this was in line with the trust’s complaints policy, which states complaints should be responded to within three working days however, the trust worked towards the national target of 180 days. Within their complaints policy, the trust states that they agree complaint resolution timelines on a case-by-case basis after consultation with the complainant.

The majority of complaints (14) related to patient care including hydration and nutrition.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

There was a trust wide policy for the management of complaints. The department displayed complaint information informing patients and visitors on how to make a complaint. The emergency department waiting room had feedback post boxes and comments cards that were available for completion at the time of visiting the department.

Staff restroom areas displayed feedback from complaints to inform staff of changes in procedure following complaints. Managers shared specific complaints outcomes to staff along with evidence of the sharing of learning.

The departmental matron gave many example of how learning was shared following a complaint. For example, the department had received a complaint in relation to the treatment of a patient experiencing an Addisonian crisis. An Addisonian crisis is a serious medical condition caused by the body’s inability to produce a sufficient amount of the hormone cortisol. In response to the complaint, staff received additional training from a specialist endocrine nurse to improve knowledge around Addison’s disease and appropriate treatment.

Senior staff within the paediatric department described a thorough approach to complaint handling which was in partnership with the divisional head of nursing and in line with the trust’s complaint policy. Staff offered families and carers the opportunity to discuss complaints on a face-to-face basis. Staff gave an example of where the complaints process had been followed in relation to a child with autism. We found the complaint had been managed in line with policy.

The paediatric emergency department used a tool to seek feedback from those who used the service. Staff gave an example of a change that occurred following feedback where the department made improvements in relation to the provision of information relating to waiting times.

Staff displayed complaints information in staff room areas and the seminar room. Staff confirmed that managers shared learning from complaints at safety huddles, which took place at regular intervals.

Is the service well-led?

Leadership

The department came under ‘The medicine and patient at home’ health care group, which was operated by a triumvirate management system, with an associate clinical director, associate director of nursing, and associate director of operations who worked together to run the health care group. Service matrons, clinical leads for each medical specialty and service managers supported the triumvirate management team.
At the time of our inspection, the role of Head of Nursing (HON) was vacant because a secondment had ended. A substantive member of staff had been appointed and was due to start this role following our inspection.

The department’s matron and general manager reported to the leadership team.

Senior leaders within the emergency department understood and could tell us the challenges that the department faced. All senior staff were passionate about delivering high quality care to patients, whilst supporting and leading staff other operational staff to achieve this.

The department’s clinical lead regularly liaised with mental health services to ensure support to vulnerable patients groups. The department understood the need to ensure equality in the care for mental health patients and was in the process of allocating designated office space for mental health staff within the department at the time of our inspection.

During our inspection, we saw that senior managers maintained high visibility within the department, to offer and provide support to staff.

The trust’s management structure was clearly displayed in staff restroom areas. All staff we spoke with knew who the local leadership team were and how to access them.

All staff we spoke with described the clinical lead and matron as approachable, supportive and visible within the department. During our inspection, we saw senior leaders, and especially the chief operating officer (COO) maintaining a visible presence and assisting at times of high demand. The COO spent 80% of their time in the emergency department.

A nurse within the paediatric department described feeling well supported by local senior nursing staff. They described their line manager as “A good leader, and of great support within the department”.

Paediatric emergency department senior nurses reported feeling supported by the head of nursing that was responsible for the paediatric emergency department.

We spoke with two members of staff who told us the trust wide management team demonstrated a visible presence, were supportive and assisted at times of high demand with maintaining flow throughout the department. Staff told us that the chief operating officer (COO) had increased the amount of time they dedicated in the department and we noted the COO actively assisting in the department during our inspection. Throughout our inspection we were told by the senior leadership team that the COO spent 80% of their workload supporting the emergency department.

Band six nurses were allocated a team of staff to mentor and support.

At the start of each shift, staff were clearly allocated to specific areas in the department. Senior nursing staff maintained regular oversight of demand in the department throughout the shift to best place staff in areas of high demand.

Vision and strategy

The trust’s values were clearly displayed in staff rooms in the department. The values were that staff were respectful, caring, responsible and committed when carrying out their role. We spoke with two staff who could both describe the service’s values. This was an improvement since our previous inspection.

The trust wide quality improvement plan linked closely with the emergency department to improve patient flow, reduce crowding in the emergency department and deliver against the four-hour
standard. We saw the department had had been re-designed with the introduction of a rapid assessment and triage area (RAT).

The overall vision was 'Your future, our hospital', which was part of the Trust’s strategy and quality improvement plan over the next five years.

The trust’s vision was supplemented by the five-year plan for all departments and specialties based on the local framework of: ‘our patients, our people, our performance, our places and our pounds’.

In September 2017, the Trust held a gathering, named ‘event in a tent’ to share the vision and strategy with staff.

The emergency department's strategy clearly outlined key aims and objectives for the service. Particular emphasis was placed on enabling the department to provide safe, respectful and compassionate care for patients. The strategy and plans were monitored on a regular basis through a variety of methods including performance meetings and through external stakeholder meetings.

The strategy was being implemented by the various healthcare group leads with support from senior management from the emergency department. This was an improvement since our previous inspection.

Culture

Staff told us they felt supported and valued in their roles. There was an open culture where staff felt able to raise concerns and suggestions to senior managers who staff described as approachable.

Staff were proud of the care they provided, despite increasing demand on the department.

We spoke with many staff, but a healthcare assistant who worked in the adult emergency department. They described the senior management team as “Brilliant, supportive and easy to approach”. They also said there had been a positive cultural change over the last 18 months and that the department had a more open and supportive culture.

We observed staff working well together and helping each other in an open, friendly but professional atmosphere. Different disciplines worked alongside each other and showed respect for each other's opinions.

Discussions with staff revealed their enthusiasm and motivation for working in the department. However, staff were frustrated at the constant shortage of staff to undertake quality care for patients although they realised the trust was working towards improving this.

We spoke with two paramedics employed by the department to monitor patients within corridor areas. Both staff described the department as supportive and that they felt valued in their role.

Staff told us that the matron and clinical lead were both highly respected and valued members of staff and that they were welcome to ideas and suggestions to improve the department.

A member of staff from the paediatric department reported feeling valued in their role.
Governance

Patient safety and quality (PSQ) meetings took place on a monthly basis. We reviewed meeting minutes from November 2017, which demonstrated regular discussion had taken place around key areas such as patient handover delays, incidents, and recruitment to vacant posts. Staff postponed the meeting scheduled for October 2017 due to operational pressures within the department. PSQ meeting minutes demonstrated that there had been a good representation of staff from the emergency department. This was an improvement since our previous inspection.

Senior clinicians and senior nurses met on a twice-monthly basis. We reviewed four sets of meeting minutes from October 2017 and November 2017, which demonstrated a broad attendance of medical, nursing, and support staff from the emergency department.

There were measures in place for risks to be escalated to the trust board. The medical health group and patient safety and quality group meeting were held monthly which reported into the trust committee on patient safety.

Management of risk, issues and performance

We spoke with the emergency department clinical lead and matron during our inspection. Both members of staff were clear in describing the top three risks on the local risk register; crowding, staffing vacancies, and failure to meet the four-hour target.

The management team identified crowding and patient flow as the top risks for the department. The department had recently undergone a period of re-design in the aim of improving flow however, due to wider hospital pressures, and temporary closure of the clinical decision unit (CDU) and surgical assessment unit (SAU) the department was experiencing increased pressures. This was an improvement since our previous inspection. Both areas were due for opening within the week following our inspection. To mitigate risk to patients and reduce the time to initial assessment, the department had recently implemented a rapid assessment and treatment (RAT) area.

The management team displayed local departmental risks throughout the department and displayed the risk register in prominent areas to inform staff of the top risks the department faced. These included overcrowding, staffing vacancies and poor flow through the department. Identified risks were in line with the trust wide corporate risk register. This was an improvement since our previous inspection.

During our inspection, the executive management team maintained regular contact with and provided support to the department to maintain and create flow within clinical areas. This was an improvement since our previous inspection. The hospital regularly had a high bed occupancy rate, which impacted on flow from the ED to other areas within the hospital.

Staffing was a key risk for the department. The department were in the process of active recruitment and were due to interview five Band 5 nurses and three Band 6 nurses following our inspection. The team mitigated risks by the use of bank and agency staff. This was an improvement since our previous inspection.

The managers reviewed the medical rotas to align with the known times of high demand within the department.

The department carried out local audits to monitor quality and patient safety. Audits included patient records, environmental cleanliness, hand hygiene and sepsis.
We saw the COO and other senior managers working alongside emergency department staff to improve flow and support staff in the department. This was an improvement since our previous inspection.

The department had recently implemented a ‘Patient safety checklist’. At the time of our inspection, staff had not fully embedded this document and it was not always completed. Senior managers described how they were trying to improve awareness of this checklist to improve compliance in completion with assistance from the quality improvement team.

However, we were concerned that staff did not complete patient safety check lists, risk assessments and day to day documentation on a routine basis to accurately reflect care and clinical treatment.

This is likely to have placed patients at increased risk and we were concerned regarding the implementation and leadership of this process.

In addition, the department frequently experienced periods of escalation due to demand in the department. This resulted in a reduced amount of time that senior staff had to carry out day to day responsibilities in relation to monitoring the quality of patient care.

**Information management**

Staff had access to policies through the trust’s intranet. We saw that staff could access policies in a timely manner.

Nurses and medical staff had access to information technology systems to track patients through journey in the emergency department. All receptionists and clinical staff had access to this system. The trust used electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

Staff locked and secured computer terminals when not in use.

Staff used electronic results systems and we noted a member retrieved diagnostic tests results in a timely manner, when treating a patient in the resuscitation room.

There was an information screen in the majors area of the department, which displayed non-identifiable patient information. This meant that staff had oversight of patients within the department, whilst confidentiality was being maintained.

During our inspection, we did not see any occasion when patient records with confidential information were left unattended. Notes from patients who had been discharged were kept securely at all times.

**Engagement**

The department engaged with patients in a variety of ways. A magazine for staff, patients and visitors was available within the waiting area. Staff displayed departmental performance for public information, for example waiting times and staffing levels.

The department used social media to advertise training days and opportunities within the department.

The trust’s public website provided a range of information for patients and visitors including alternative support options including NHS 111, GP and pharmacy services.
Staff described an improved culture of openness both locally and with the trust wide senior management team. Two members of staff described the implementation of a weekly meeting with the chief executive, which gave them the opportunity to raise concerns and feedback information.

**Learning, continuous improvement and innovation**

The paediatric emergency department was passionate about developing the existing team and offering opportunities in new roles such as emergency nurse practitioners.

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

#### Facts and data about this service

The medical care service at the Princess Alexandra Hospital provides care and treatment for nine specialities. These include:

- Gastroenterology
- Respiratory
- Diabetes
- Endocrinology
- Care of the elderly
- Frailty
- General medicine
- Neurology
- Dermatology
- Cardiology

At the Princess Alexandra Hospital there are 270 medical inpatient beds across 13 wards.

*(Source: Routine Provider Information Return - Acute-Sites)*

The trust had 27,231 medical admissions from August 2016 to July 2017. Emergency admissions accounted for 15,360 (56%), 211 (1%) were elective, and the remaining 11,660 (43%) were day case.

Admissions for the top three medical specialities were:

- General medicine: 13,056
- Gastroenterology: 4,133
- Clinical haematology: 3,119

*(Source: Hospital Episode Statistics)*

During our inspection, we visited the following medical departments and wards: Harold Ward, Harvey Ward, Lister Ward, Locke Ward, Ray Ward, Winter Ward, Saunders Ward, John Snow
Ward, the ambulatory care unit, the endoscopy unit, cardiac catheterisation laboratory ward, the medical admissions unit (MAU), and the discharge lounge.

During our inspection, we spoke with 13 medical staff, 24 nursing staff, five healthcare assistants, two patient journey coordinators, two physiotherapists, and nine patients and relatives. We looked at performance information and data from, and about the trust. We reviewed 17 sets of patient records along with other documents such as team meeting minutes and trust policies. We obtained feedback through Healthwatch and from reviewing the results of the NHS Friends and Family Test. We also undertook interviews with key members of staff and held focus groups as part of our inspection.

We last inspected this hospital in June and July 2016 and rated medical care (including older people’s services) as requires improvement overall, with safe and responsive being rated as requires improvement.

**Is the service safe?**

**Mandatory training**

The trust set a target of 95%90% for completion of mandatory training.

Up to July 2017, nursing and midwifery registered staff within the medicine health care group did not meet the 95% target for any of the five modules they were required to complete, whilst, dental and medical staff did not meet the 95% target for any of the four modules they were required to complete.

![Mandatory training completion](chart.png)

**Mandatory training completion (registered nurse and midwifery)**

<table>
<thead>
<tr>
<th>Training</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;D</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>IG</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Manual handling level 2</td>
<td>71%</td>
<td></td>
</tr>
</tbody>
</table>
Nursing staff within the medicine health care group had a better completion rate compared to the medical and dental staff with 75% compared to 47%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training modules included Moving & Handling Level 2, Equality and Diversity, Information Governance, Infection Control Level 2, and Fire.

Throughout our inspection, the majority of nursing and health care assistant staff we spoke with said they were able to access mandatory training and that training opportunities were good. One member of nursing staff told us they were being supported by the trust to train as an advance nurse practitioner.

Training was delivered through a mix of e-Learning packages, and face-to-face classroom sessions.

There were systems and processes in place to ensure newly appointed, bank and agency staff completed local inductions and mandatory training.

Updated levels of mandatory training were presented on white boards on each ward to inform members of the public of the current levels of mandatory training compliance.

Ward managers and matrons told us that mandatory training compliance was not meeting the trust’s target for compliance, mostly due to staff shortages, which led to difficulty in releasing staff from the ward.

We requested up to date mandatory training levels at the time of our inspection, which showed nursing staff had completed 87.7% of the mandatory modules on average. Medical staff had completed 63.12% of mandatory training on average. Mandatory training levels across the service had improved since our last inspection. However, they remained below the trust target.

Mandatory training included:
- adults & paediatric basic life support
- equality, diversity and human rights
- fire - general awareness
• immediate life support
• Infection prevention & control
• moving & handling
• prevent/Health Wrap,
• safeguarding Adults
• safeguarding children
• values & Behaviours.

Sepsis training was not currently part of mandatory training. However, the sepsis lead informed us that a mass training programme in sepsis was being rolled out across the trust for all staff to receive as part of their induction.

**Safeguarding**

The trust set a minimum target of 90% for completion of safeguarding training. The completion rate was 82% for nursing staff in both Safeguarding Adults level 2 and Safeguarding Children level 2.

Registered nursing and midwifery staff within the medicine health care group did not meet either target for the two safeguarding modules they were required to complete.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The hospital had policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and female genital mutilation. Staff could access these policies through the hospital intranet system.

Despite staff not meeting the trust mandatory training target for safeguarding, all the nursing staff we spoke with understood their responsibilities in terms of safeguarding adults and children. All the nursing staff we spoke with told us how they would report a safeguarding concern and what they would report.

There was a designated safeguarding lead within the hospital. Staff we spoke with knew who the lead was and were able to describe how they would contact them.

We requested up to date safeguarding training levels for all safeguarding training following our inspection, which showed nursing staff completion of safeguarding children level one was 88.9%, level two 89.2% and level three 100%. Medical staff completion of safeguarding children level one was 50%, level two 66.67%, and level three 100%. Safeguarding adults level one was completed by 100% of nursing staff and 50% of medical staff. Safeguarding level two had been completed by 87.57% of nursing staff and 61.47% of medical staff. Neither nursing staff or medical staff met the target for safeguarding modules. However, the data provided following our inspection-evidenced level of completion were improving.

One member of nursing staff told us they had recently raised a safeguarding concern regarding a vulnerable adult. The member of staff told us they had received feedback on the safeguarding outcome.

Nursing staff described the trust wide Daisy project, which was a trust wide initiative designed to help in recognising and responding to people at risk of domestic harm.
The trust had ratified a female genital mutilation (FGM) policy in May 2016, which staff could access through the intranet.

The trust did not routinely use a depression/anxiety screening tool but if depression was identified during an initial assessment, staff could contact appropriate psychology teams for support.

**Cleanliness, infection control and hygiene**

All clinical areas we visited were visibly clean. Nursing and medical staff adhered to the trust hand hygiene and ‘bare below the elbow’ policy, and wore personal protective equipment (PPE) such as gloves and aprons during care.

The service conducted monthly audits on infection control and hygiene, which was submitted for a trust wide ‘Knowing How You Are Doing’ Monthly Performance Report, which was presented to the trust executive team.

There were no cases of MRSA bacteraemia reported in medical care services between April 2017 and October 2017.

There were no cases of MSSA bacteraemia reported in medical care services between April 2017 and October 2017.

There were eight cases of Clostridium Difficile reported that were acquired across the medical service between April 2017 and October 2017.

Staff completed hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

Staff washed their hands in line with the World Health Organisation’s ‘Five Moments of Hand Hygiene’ guidance between personal care activities with patients and utilised the hand sanitiser where appropriate.

Hand sanitiser was available at the entrance to each ward area and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas.

All wards we visited had a stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.

Nursing staff displayed results from the most recent monthly hand hygiene and ward cleanliness. The October 2017 Medical Healthcare group hand hygiene audit showed a compliance rate of 93% across the group against a trust target of 98-100%. However, this data includes the Emergency department results. The worst performing medical ward was Lister ward at 75%. However, Harvey ward, Harold ward, Gibberd ward, Locke ward and the endoscopy unit all achieved 100% compliance.

Nurses identified patients who required isolation and were treated in side rooms where doors were kept closed to reduce the risk of the spread of infection.

All the items we checked were visibly clean and displayed green “I am clean” stickers with the date of cleaning to items to identify those that had been cleaned and were ready for use. This ensured there was no cross contamination between patients using the same equipment.
In the Endoscopy unit, there was a clear pathway for clean and contaminated equipment to prevent cross contamination. The equipment was being decontaminated and stored in line with national guidance. Records were in place that provided full audit and traceability process.

Endoscopy staff carried out screening of at risk patients for communicable diseases prior to carrying out a procedure.

Nursing staff screened patients for communicable diseases such as MRSA on first admission into the department. If a patient was admitted with MRSA staff followed the Infection prevention and control policy regarding ongoing monitoring and isolation.

**Environment and equipment**

We examined a sample of equipment check labels, for example on airflow mattresses, blood pressure monitors, hoists and patient monitoring equipment, amongst others. All equipment had been serviced and calibrated in line with manufacturers guidelines.

Resuscitation equipment was visibly clean and was stored in an accessible location on all the wards we visited. The department had introduced pre-packed consumable equipment trays on resuscitation trolleys in order to ensure staff had access to necessary items in a timely manner.

We reviewed a sample of consumable equipment, and oxygen canisters and found they were all within date.

We reviewed records of safety checks for resuscitation equipment from 1 November to 5 December, which showed that staff completed daily checks on all wards we visited. However, on x ward

We inspected the storage and expiration dates of consumable items, for example syringes, personal protective equipment and catheters on all wards we visited. Consumables were stored correctly on most wards. However, we found out of date and incorrectly disposed of consumables (syringes and electrocardiogram (ECG) dots) on Ray ward. This was raised with the ward manager who disposed of the equipment at the time of the inspection.

Patient trolleys, equipment, and curtains providing privacy, were visibly clean throughout the wards. Curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.

All wards displayed signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of each ward.

Staff managed clinical waste in line with trust guidance. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted that domestic staff routinely emptied waste bins during our inspection.

Nursing staff correctly labelled and secured sharps bins. We inspected sharps bins on each of the wards we visited and saw that staff did not overfill any of the sharps bins.

All wards we visited had secure access through a buzzer system. This meant that visitors had to request access to each ward area.

**Assessing and responding to patient risk**

From August 2016 to July 2017, all individuals moved wards once or more during their admission. The trust only provided data for 595 bed moves for medicine. However, the trust did tell us there have been 1,702 moves during the night between 10am to 6am for medical wards.
Staff told us that the number of bed moves was improving across the service and the new Medical Assessment Unit (MAU) and short stay ward was designed to help reduce the number moves required for each patient. However, data provided by the trust prior to the inspection showed the number of bed moves remained high.

The medicine team could refer patients to the critical care unit, which can accommodate both intensive (level 3) and high dependency (level 2) patients.

The trust provided mental health nurse cover 24 hours a day, seven days a week for adults. Information on how to make a referral to the mental health nurse was displayed at the nurses station on each ward.

All the records we reviewed showed that medical patients had a medical review every 24 hours.

Staff used national early warning scores (NEWS) on the medical wards to continually monitor, assess and identify any deteriorating patients. All records we reviewed showed that staff routinely completed NEWS and alerted senior staff to any patient that may be deteriorating.

Nursing staff completing patient observations on hand held computer tablets. The tablets provided the ward manager and matron an overview of patients and provided continuity between nurses and shifts. In addition, if a patient was triggering on their NEWS, this alerted the critical care outreach team (CCOT) who were able to take appropriate action in accordance with the patient’s observations.

We reviewed 17 patient records in the ward areas we inspected. There were standard risk assessment tools completed on admission, which staff completed in all patient records we saw. This was followed by use of specific tools for pressure ulcer risk, moving and handling, and bed rails risk, nutrition, falls, and dementia screening. These were included in an assessment booklet, which different professional and care staff could use.

All the wards we visited had a named sepsis champion. Sepsis champions are staff members that undertake sepsis training and in turn provide sepsis training to other staff members in their department or ward. We observed nursing staff using the sepsis six screening tool. A NEWS score indicative of sepsis sent an automatic electronic alert to and prompted the nurse to seek medical input for the patient concerned.

All the medical records we reviewed evidenced that the service was meeting the NHS services, seven days a week priority clinical standard two in that all emergency admissions were seen by a consultant within 14 hours of arrival at the hospital.

Nursing staff identified patients at risk of developing pressure sores using the Waterlow risk assessment scores. These patients wore pressure-relieving boots to protect their ankles and used pressure relieving air mattresses to try to reduce the risk of pressure sores developing.

**Nurse staffing**

The Princess Alexandra Hospital had reported their staffing numbers below for the period April 2017 to July 2017 for Medicine.

For the medicine health care group the trust told us that they had 93.57 fewer whole time equivalent (WTE) qualified nursing staff then they had planned to provide safe care.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing group</strong></td>
<td><strong>WTE Staff</strong></td>
<td><strong>Number in post</strong></td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>243.19</td>
<td>149.62</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From August 2016 to July 2017, the trust reported a vacancy rate of 16% in medicine, and the highest reporting wards were:

- Ray ward: 32%
- Locke ward: 31%
- Winter ward: 25%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The trust used the ‘Safer Nursing’ acuity tool to allocate staff based on patient acuity, which is a measurement of the intensity of nursing care required by each patient.

Most of the wards we visited had vacancies for either registered nurses (RNs) or health care assistants (HCAs). We noted during our inspection that most wards were understaffed against the planned establishment. In these cases, the trust used agency or bank staff.

All wards displayed a planned and actual level for nursing and healthcare assistant staff. Nursing staff moved between wards to cover for staff shortages when required. We saw a ward manager discussing moving staff between the MAU and Saunders ward and including staff in the discussion. Staff told us they felt they had sufficient support when being asked to move between wards to cover for staffing issues.

Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and any patient safety issues. We observed a nursing handover on Locke ward, which included a detailed discussion of each patient at their bedside with all nursing staff on the oncoming shift in attendance.

Senior managers were fully aware of staffing concerns across the medical wards and significant recruitment initiatives had been undertaken and continued at the time of our inspection. Staffing concerns had been raised on the trust’s risk register and managers, including the matrons and associate heads of nursing, maintained a visible presence throughout the clinical areas to support staff.

Turnover rates

From August 2016 to July 2017, the trust reported a turnover rate of 38% in medicine, which is higher than the trust target of 11% the highest reporting units were:

- Complex care division: 22%
- Speciality medicine division: 15%
- Elderly and stroke division: 14%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From August 2016 to July 2017, the trust reported a sickness rate of 2.1% in medicine compared to the trust target 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From August 2016 to July 2017, the trust reported a bank and agency usage rate of 38% in Medicine. There were a number of wards where bank and agency usage was regularly above 50%. The highest reporting ward was:

- Harvey ward with 67%

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Ward managers told us that agency and bank staff regularly covered night and weekend shifts across the medicine health care group.

Agency nurse records included oversight of mandatory training and intravenous (IV) competencies, which were checked by ward managers prior to commencement of work within the department.

We requested the average fill rate data, which is the actual vs planned staffing levels on the wards, for October and November 2017. The data showed an average nursing fill rate during the day of 59.2% on medical wards in October and 71.6% in November. The fill rates on night shifts was consistently better than during the day, which was due to agency staff covering unfilled night shifts.

Agency nursing staff received an induction prior to commencement of work in the service, which included an orientation of the ward and how to locate hard copies of policies and procedures. The induction included intravenous (IV) training, various competencies, and safeguarding. Agency staff were provided computer system training to allow them access to online policies and procedures. The service always tried to book the same agency staff, and those that were known to them in order to ensure continuity of care and mitigate any risks associated with using staff that were not familiar with the hospital.

The hospital site managers reviewed staffing levels and skill mix three times a day to enable real time adjustments to be made to meet the demands of patients across the medical wards. Patient demand was measured using a Safer Nursing care tool and in light of the high number of vacancies, validations were sought form matrons to strengthen that quality of the information. In addition, there was always an executive on call and there was a robust system to escalate any concerns in order to maintain safety across the hospital. We saw this procedure was in operation throughout our unannounced evening inspection to the trust.

Medical staffing

The trust has reported their staffing numbers below for the period up to July 2017 for Medicine.

As at July 2017, there were 12.44 fewer whole time equivalent (WTE) medical staff then the trust had planned to provide safe care within medicine.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>93.40</td>
<td>80.96</td>
</tr>
</tbody>
</table>
Vacancy rates

From August 2016 to July 2017, the trust reported a vacancy rate of 21% in medicine, and the highest reporting areas were:

- Medical staff stroke: 88%
- Medical staff elderly: 33%
- Medical staff gastroenterology: 18%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From August 2016 to July 2017, the trust reported a turnover rate of 11% in Medicine, which is the same, compared to the trust target of 11% the highest reporting units are:

- Elderly and stoke division: 38%
- Speciality medicine division: 7%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates within Medicine were lower that the trust’s target for sickness rates. From August 2016 to July 2017, the trust reported a sickness rate of 2.1% in Medicine compared to the trust target 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

From August 2016 to July 2017, the trust reported a bank and locum usage rate of 22% in Medicine. There were 858 shifts covered by bank staff and 3,220 shifts covered by locum staff between August 2016 and July 2017.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Locum doctors completed an induction pack prior to commencement of work in the department. The Induction included access to computer systems.

Staffing skill mix

As at July 2017, the proportion of consultant staff reported to be working at the trust was in line with the England average and the proportion of junior (foundation year 1-2) medical staff was similar. Staffing skill mix for the whole time equivalent (WTE) staff working in medicine can be seen below.
Despite the number of medical staff in post being lower than the establishment, there was evidence that medical staffing was providing safe patient care, for example each ward still had a named consultant responsible on the ward and patients we spoke to felt they had sufficient discussions with medical staff. The trust used locum doctors to fill vacant shifts.

During our inspection, we spoke with 13 medical staff including consultants and junior doctors (FY1 and FY2). A Foundation doctor (FY1 or FY2) is a grade of medical practitioner undertaking a Foundation Programme. This is a two-year, general postgraduate medical training programme, which forms the bridge between medical school and specialist and general practice (GP) training. Medical staff told us they felt supported, but they acknowledged recruiting consultants remained a challenge.

There were daily board rounds on speciality medical wards, which included multidisciplinary discussion of each patient’s medical care and plans for discharge.

A medical handover took place every morning, seven days a week, which included discussion of clinical incidents, significant patients, scans, and investigations requiring urgent review. The handover meeting also included a review of medical staffing gaps and agreed redistribution of doctors.

All the wards we visited had a resident consultant and a number of junior doctors based on the ward.

Medical staff worked on a rota system, which provided medical cover to the wards 24 hours a day, seven days per week. Junior doctors contacted consultants by mobile phone for advice and support when required at night.

At weekends, the department utilised physician of the day who was available on site between 8am and 8pm and on call overnight.

**Records**

We reviewed 17 sets of medical and nursing care records as part of this inspection. All records were paper based apart from physiological observation records, which staff recorded on hand held
devices. Staff kept patient records either outside the patient’s room, or at the end of the patient’s bed and in lockable records trolley by the nurse’s station. However, staff did not always lock trolleys when not in use meaning records were not secure at all times, for example on Ray ward we observed a trolley that was left unattended whilst medical staff undertook their ward round. This meant unauthorised people could have accessed these records. We raised this with the ward manager who told us they would speak with the doctors.

Records included details of patients’ mental health, learning disability and dementia needs where appropriate.

Staff completed risk assessments and reviews frequently during the patient’s admission. Risk assessments included National Early Warning Scores (NEWS), Malnutrition Universal Screening Tool (MUST), Waterlow score (a tool for assessing the risk of developing a pressure sore) and falls risk assessments amongst others.

We found good evidence of multidisciplinary team recording in patient records, to provide accurate details of care pathways needed to ensure consistency of care.

All of the records we reviewed were legible and were signed and dated by staff.

Information stored electronically was secure. We witnessed computers staff locking computers when not in use and these were password protected to prevent unauthorised access to them. This helped to ensure patient identifiable information was protected.

People prescribed an antimicrobial had the clinical indication, dose and duration of treatment documented in their records.

**Medicines**

Staff could access the trust medicines policy through the intranet or as a hard copy at each nurses’ station.

Nursing staff locked medicine trolleys when not in use and secured them to the wall or stored them in the locked clean utility room in all the wards we visited. Two medicine trolleys on Fleming ward were unclean and contained medicines not in their original packaging and in some cases, expiry dates were not visible.

We found that there were effective systems in place for medicine management with regard to handling, storage, and security of medicines. On all the wards we visited, staff stored medication in locked rooms, neatly within locked cupboards.

Controlled drugs (CD) records were legible and dated by nursing staff without any omissions and CD’s were stored securely in an appropriate cupboard within the medicines storage rooms. Controlled drugs are medicines controlled under the Misuse of Drugs legislation (and subsequent amendments). Examples include morphine, pethidine, and methadone. Regulations state that controlled drugs should be secured in a lockable wall mounted cupboard with only authorised staff having access to keys.

Books used for recording medication fridge temperatures on wards we visited were well maintained and completed daily. For example on Saunders ward and Jon Snow ward amongst others, staff recorded the refrigeration temperatures between October and December 2017, with no omissions. We noted if the fridge temperature exceeded the stated range, staff would record the details. However, on five occasions where the temperature was recorded as being out of range no action or escalation took place. This meant that medication could have been compromised. The
service had improved the recording of fridge temperatures across the service since our last inspection. However, staff did not record any action taken when concerns were identified.

Staff did not monitor or record the ambient room temperatures in areas where medications were stored. This meant staff had no way of ensuring room temperatures were in an acceptable range in which medication could be safely stored. We raised this as a concern with the trust.

All the wards we visited had a named pharmacist that visited the ward regularly and followed up on any medication or stock query from the ward staff. A clinical pharmacist reviewed all prescription charts each weekday.

Patients were encouraged to self-administer their own medications where appropriate and following a risk assessment.

We checked the expiry dates on a selection of medications on the ambulatory care unit, Saunders ward, Lister ward, Winter ward, Ray ward, and Henry Moore ward including CDs, bags of fluid and other medications. Most of the medications we checked were in date and stored according to manufacturer’s storage condition. However, on Fleming ward we found out of date medications on one of the trolleys. We raised this with the pharmacy team and nurse in charge and the trust rectified this concern during our inspection.

We reviewed 14 patient medication administration records (MARs). Allergies were clearly recorded on the medication chart. Records were accurately documented and reflected the needs of the patients.

We observed patients and their relatives having being shown their medication and a member of nursing staff explaining it to them while being prepared for discharge.

Incidents

From October 2016 to September 2017, the trust reported no incidents classified as never events for Medicine. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Source: NHS Improvement - STEIS (October 2016 to September 2017)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in Medicine, which met the reporting criteria set by NHS England from October 2016 to September 2017.
Of these, the most common type of incident reported was:

- Two sub-optimal care of the deteriorating patient meeting SI criteria (33% of total incidents).
- One treatment delay meeting SI criteria (17% of total incidents).
- One pending review (a category must be selected before incident is closed) (17% of total incidents).
- One slips/trips/falls meeting SI criteria (17% of total incidents).
- One pressure ulcer meeting SI criteria (17% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The trust had an incident reporting policy that staff could access online. All staff we spoke with knew how to report incidents on the trust electronic reporting system and told us they received feedback from any incidents via email, face to face from their line manager, or at team meetings.

On all the wards we inspected, learning from incidents was displayed on staff notice boards. Feedback on the incident included what went wrong, the method of reporting and all actions taken by the trust to prevent the incident happening again. We saw an example where an incident involving a patient on Jon Snow ward being incorrectly hoisted was shared with staff through notice boards in staff areas on other medical wards.

Staff also told us they were actively encouraged to report incidents by their managers, to enable learning and to ensure incidents were minimised in the future.

We reviewed the route cause analysis (RCA) of three serious incidents (SIs). All of the SIs had been investigated in line with the trust's policy, and detailed the recommendations and actions taken to minimise events in the future. Staff could access the governance and learning folder at any time and SIs were discussed at team meetings.

The trust held daily serious investigation group (SIG) meetings where all new incidents were discussed to grade the incident and to make a decision about the course of action that should be taken to investigate the incident. The chief medical officer and the chief nurse chaired the SIG meeting.

The individual medicine health care group specialisms held monthly mortality and morbidity meetings that included a wide range of multi-disciplinary support. The trust did not minute these meetings, because they took place as case discussions. If anything came out of the meetings that needed highlighting to a wider group it was shared through clinical leads and ward managers. We reviewed the December 2017 case discussion presentations for one care of the elderly patient and three gastroenterology patients. There was clear evidence of review of the patients care from arrival, diagnosis treatment and death. The trust also evidenced learning from the meetings at the end of the presentations.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong. We saw evidence of staff invoking the duty of candour in response to an incident on John Snow ward.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed the trust had reported 34 new pressure ulcers, 11 falls with harm and 27 new catheter related urinary tract infections (UTIs) from October 2016 to October 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Princess Alexandra Hospital NHS Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (34)</th>
<th>Total Falls (11)</th>
<th>Total CUTIs (27)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

(Source: Safety thermometer - Safety Thermometer)

Nursing staff collected information for the NHS safety thermometer. This was clearly displayed on notice boards on all the wards we inspected. This meant this information was readily available for members of the public to see.

We reviewed the medicine wide nursing dashboard for November 2017. Nursing staff recorded the number of avoidable and unavoidable pressure ulcers (Pus) and number of falls. Nursing staff told us that the safety thermometer results were discussed at team meetings.
**Is the service effective?**

**Evidence-based care and treatment**

Staff were aware of the National Institute for Health and Care Excellence guidance (NICE) relevant to their speciality and we saw they had access to guidance via the trust’s intranet, for example for diabetes in adults, heart failure and kidney disease.

Patient care was delivered in line with trust policies and pathways based on national guidance including. For example, across the medicine health care group, staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed 14 medication prescription charts, all of these demonstrated where patients had received a VTE risk assessment and had precautionary VTE medication if indicated.

Local policy and procedure guidelines for all specialties were available on the trust intranet and were easily accessible by all members of staff. Regular audits of documentation were undertaken on all wards to ensure care was following best practice and identify areas that required improvement.

Local audits were also taking place in the medicine division, for example hand hygiene, venous thromboembolism (VTE) and national early warning scores (NEWS).

Nursing staff used the sepsis six screening tool, which is best practice for the early identification of sepsis.

Consultants conducted formal ward rounds to review patients twice a day on the Medical Assessment Unit.

The trust had achieved The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation since our last inspection.

Once transferred from an acute area of the hospital to a general ward, doctors reviewed patients during a consultant-delivered ward round at least once every 24 hours Monday to Friday. The physician of the day was available on site between 8am and 8pm on weekends to review patients that required daily review.

**Nutrition and hydration**

The medical wards used a ‘red tray’ system to identify patients who needed help with eating. This enabled staff to identify and monitor those patients who needed encouragement or special diets in order to maintain their well-being.

Staff completed a nutritional assessment for all patients on admission to the wards. The trust used the malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition. We reviewed 17 patient records and found that in all cases where it was appropriate the MUST score had been completed and the patient’s fluid and diet chart completed and escalated accordingly. Staff made referrals to a dietician when patients were at high risk of malnutrition.

We saw that patients had access to water jugs at the bedside, these were within patients’ reach.

Meal times were well organised and not rushed. Staff ensured that patients, where possible, were sat up in bed or at tables to eat meals.

Staff encouraged patients to eat meals in the hospital canteen where possible to aid their recovery and increase independence.
Patients we spoke with said staff gave them choices of food and snacks. Patients generally told us that the food was good quality and there was enough choice.

Mealtimes were protected. This meant that during lunch and evening meal times all non-urgent activity on the wards stopped so that nurses and health care assistants (HCAs) were able to help with the meal service and provide extra assistance for those patients that needed it. There was sufficient staff to assist patients in eating and drinking at the meal times we observed.

**Pain relief**

We reviewed 17 sets of patient care records during our inspection, and found that staff routinely recorded the patient’s level of pain on the early warning score (EWS) chart in line with the trust’s policy.

Staff asked patients to rate their pain each time they took their physiological observations and staff assessed patient pain. Staff completed pain charts appropriately in all patient notes we reviewed.

Patients told us that they were always asked about pain during medication administration rounds. We examined prescription charts, and saw that as required medication was prescribed and administered for pain where appropriate.

The services were able to access the specialist pain team and staff told us they responded quickly when an assessment was required. Staff told us they could use specialist assessment tools for patients who could not verbalise, for example the Abbey Pain Scale for people with dementia or communication difficulties.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From July 2016 to June 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective admissions**

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions

**Non-Elective admissions**

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions
From July 2016 to June 2017, patients at Princess Alexandra Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions
- Patients in medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions

Non-Elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

_Total:

_Elective Admissions - Princess Alexandra Hospital_
National Diabetes Inpatient Audit

The national diabetes inpatient audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year, quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 national diabetes inpatient audit identified 48 inpatients with diabetes at Princess Alexandra Hospital, 78.7% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one. In the 2015 audit the trust scored 83.7% showing a decline between the two audits.

(Source: NHS Digital)

- The clinical lead for diabetes told us the trust had recently employed a nurse who responsibilities would include data collection and quality assurance in diabetes care.

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2014 to March 2015, 44% of nSTEMI patients were admitted to a cardiac unit or ward at Princess Alexandra Hospital and 100% were seen by a cardiologist or member of the team compared to an England average of and 55% and 95.1%.

The proportion of nSTEMI patients who were referred for or had angiography at Princess Alexandra Hospital was 82.6% compared to an England average of 79%.
<table>
<thead>
<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Alexandra Hospital</td>
<td>25</td>
<td>25</td>
<td>23 (23)</td>
</tr>
<tr>
<td>England: overall</td>
<td>100%</td>
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<td>45,500</td>
<td>45,500</td>
<td>38,099 (38,099)</td>
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<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 lung cancer audit and the proportion of patients seen by a Cancer Nurse Specialist was 49%, which was worse the audit minimum standard of 90%. The 2015 figure was 91%.

The proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) receiving surgery was 23.8%, this is better than the national level. The 2015 figure was 37%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 65.7%, this is similar to the national level. The 2015 figure was 32%.

The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 47.6%, this is worse than the national level. The 2015 figure was 57%.

The one-year relative survival rate for the trust in 2016 is 34.6%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust had a multi-disciplinary working group for falls prevention where data on falls were discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 13.8% this was worse than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 3.8% this was worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 20% this worse than the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 25% this was worse than the national aspirational standard of 100%.

(Source: Royal College of Physicians)

On Harold ward, a specialist orthopaedic recovery ward under the supervision of the medicine
health group, we saw staff appropriately using specialist fall beds that a falls risk assessment had been completed for all patients and all patients had an appropriate mobility aid and call bell within reach. The trust had also produced a ‘My hip fracture care’ advice leaflet for all patients that provided information on their care and advice on how to reduce their risk of falls.

The trust held weekly Multidisciplinary team (MDT) meetings to discuss patient outcomes. We reviewed three sets of meetings minutes from December 2017 that included a detailed discussion on the reason for each review, details of the patient outcomes and a next review date if required.

**Competent staff**

From September 2016 to August 2017, 47% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%. In the last financial year (March 2016 to April 2017), the appraisal rate was 57% for staff within medicine.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The trust was not meeting the target for medical directorate staff appraisal. However, all the nursing staff we spoke with confirmed they had received an annual appraisal or had one scheduled. Staff told us that as part of their appraisal, they discussed their development and any training needed for their revalidation.

There were systems and processes in place to ensure newly appointed staff, bank and agency staff completed local inductions. We spoke with agency nurses and health care assistants (HCAs) who told us they received an induction to their specific ward. We saw evidence that local inductions took place on each ward we inspected and these were kept in folder either in the office or at the nurses’ station.

We spoke with two student nurses who told us they had a mentor and had been very well supported by other nursing staff.

We requested up to date staff appraisal rates at the time of our inspection, which showed 82% of nursing and support staff had received an appraisal and 97% of medical staff had completed an appraisal. Appraisal rates had improved since our last inspection.

The trust Integrated Dementia Strategy/Delivery Plan from March 2017 included a plan for all staff to receive Tier one training on induction in the form of a vulnerable patient study day and 100% of clinical staff to receive Tier two training. All medical wards had a dementia champion, who was a qualified nurse that had received extra training in working the patients with dementia and supporting other staff.

**Multidisciplinary working**

During the inspection, we saw regular multidisciplinary meetings or rounds on wards. There was a joined-up and thorough approach to assessing the range of patients’ needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

We saw the daily inpatient board rounds and routine ‘Red to Green’ patient management meeting during the daily ward governance huddles. Red to Green is an initiative that helps turn patients’ ‘red days’ into value adding ‘green days’, which help to facilitate a safe discharge from hospital. A red day is when a patient does not receive an intervention to support their pathway of care.
Ward teams had access to a range of allied health professionals and team members described good collaborative working practices between the teams. All staff described teams working well together and sharing best practice to improve patient outcomes.

Patient records showed multidisciplinary care and treatment took place. For example, occupational therapists, physiotherapists, and speech and language therapists fully documented patient progress and updates within the patient care record. Information was recorded within the patient’s daily records.

Patients with complex needs received prompt screening by a multi-professional team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff to ensure a treatment and management plan was put in place as soon as possible.

There was joint working with discharge coordinators physiotherapists who were based on individual wards to ensure a consistency in approach for each patients discharge. The discharge coordinators would review every patient awaiting a rehabilitation bed and attend ward rounds to promote early intervention and discharge where possible.

The trust held regular Multidisciplinary team (MDT) meetings for people with complex needs, for example, patients with learning difficulties that would require extra support upon discharge, which included input from local social services.

Details of a patient’s assessments and ongoing care were shared with their local GP on discharge for example about tissue viability (pressure risk) and nutritional assessment.

**Seven-day services**

Access to seven-day services had improved since our previous inspection.

Consultants worked Monday to Friday with on call cover overnight and at weekends.

The endoscopy service was operational six days a week but was not yet a seven-day service due to staffing levels. The unit did not have a gastrointestinal (GI) bleed rota. However, the service had emergency trolleys in theatres in case of GI bleeds. All theatre staff were trained in endoscopy and how to treat GI bleeds and the service employed a ward sister who was trained in treating GI bleeds.

Staff could access a range of imaging services, including; X-ray, magnetic resonance imaging (MRI) and computerised tomography (CT) scanners 24 hours a day, seven days a week, facilitated by a team of radiographers. An outside provider interpreted results and fed back to staff within indicated timeframes.

The alcohol liaison nurse was available Monday to Friday.

Staff reported good access to therapies such as physiotherapy, occupational therapy and speech and language therapy Monday to Friday, with reduced access at weekends for physiotherapy and speech and language therapy.

Learning disability support nurses were available Monday to Friday. Outside of these hours, staff flagged patients to the site team for the nurse specialist to pick up the following day.

The trust provided mental health nurse cover 24 hours a day, seven days a week for adults.

There was access to psychiatry through a doctor’s referral to a team that was based in a mental health services centre that was based in the hospital and was managed by a separate provider.
Health promotion

The trust provided a range of leaflets available to support patients’ recoveries and encourage healthier lifestyles for example on smoking cessation and healthy diets.

Patients were supported to mobilise as soon as safely possible after surgery on medical wards and were encouraged and supported to get out of bed, dressed and take meals in the hospital canteen, which promoted a speedier recovery and discharge.

The trust employed an alcohol liaison nurse who worked within the medical health group to follow alcohol pathways.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for their self. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. DoLS aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) training was undertaken as part of safeguarding training. At the time of our inspection, 82% of staff had completed this training, against the trusts’ target of 95%.

(Source: Trust Routine Provider Information Return P40)

Staff could access the trust’s ‘Mental Capacity’ policy, which was based on relevant legislation. It provided clear reference to staff and cross referred to trust policies on Deprivation of Liberty, Consent Policy and Safeguarding.

Nursing staff told us that members of the safeguarding team were available to provide advice and guidance relating to MCA and DOLs.

Staff carried out mental capacity assessments (MCA) and (DoLS) appropriately throughout the medical wards. We reviewed six MCA assessments and four DoLS records. Medical staff had completed them appropriately, evidenced discussions with each patient’s family having signed and dated them. However, on Harold ward we found one DoLS record that had not been signed and dated correctly. This was raised as a concern to the nurse in charge who arranged for the DoLS to be completed correctly.

We observed nursing staff seeking patient consent verbally before undertaking aspects of care.

Is the service caring?

Compassionate care

During our inspection, we spoke with nine patients and their relatives or carers.

Throughout our inspection, we observed staff being polite and courteous to patients and respond compassionately to patients’ needs throughout our inspection.

We observed nurses and a Health Care assistant (HCA) on Locke ward comforting a patient who
was distressed at night. Staff offered reassurance to the patient until they became less distressed and returned to their bed.

Nursing and medical staff preserved patient privacy and dignity by closing curtains before carrying out care. They also asked for permission before entering patient rooms and curtained bed spaces.

Nursing staff closed bay and side room doors while having ‘white board’ meetings in order to protect patient confidentiality. White board meetings are staff huddles that take place in the mornings during which staff discuss each patient’s individual medical care needs, any planned procedures, and discharge planning.

All patients we spoke with were positive about the caring attitude of staff at the hospital and described the staff as being polite and helpful.

**Friends and Family test performance**

The Friends and Family Test response rate for Medicine at the trust was 41%, which was better than the England average of 25% from September 2016 to August 2017.

The table below shows the average response rate and the percentage recommended for all of the medical wards, response rates vary between 25% for the winter ward to 92% for the John snow unit.

**Friends and Family test performance from September 2016 to August 2017**

<table>
<thead>
<tr>
<th>Princess Alexandra Hospital</th>
<th>Total Resp</th>
<th>Resp. rate</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
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<th>Jun-17</th>
<th>Jul-17</th>
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<tbody>
<tr>
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<td>89%</td>
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<td>48%</td>
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<tr>
<td>John Snow Unit</td>
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<td>STRO</td>
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<td>69%</td>
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<tr>
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<td>79%</td>
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</table>

(Source: NHS England Friends and Family Test)

**Emotional support**

There was a trust wide chaplaincy service and we saw this advertised on notice boards within the wards.

There were faith champions on each of the wards to facilitate emotional and spiritual care.

We observed staff providing support to relatives and offering access to family rooms for privacy.

**Understanding and involvement of patients and those close to them**
Staff routinely involved patients and their relatives in care planning and decision-making, for example Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs) and discharge planning. This was evidenced in patients’ medical care records.

At ward rounds, we observed doctors involving patients in the discussions and asking patients whether they had anything they would like to ask or whether they needed any clarification.

All the patients we spoke with said they had felt involved in their care planning and decision-making.

All the wards we inspected clearly displayed visiting hours and wards that specialised in caring for patients with dementia had open visiting hours, which meant that relatives and carers could stay on the wards to help with their care and support at meal times.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Since our last inspection, the trust had introduced a ‘Patient at Home’ service to facilitate early supported discharges. This service delivered care to patients in their own home, for example the administration of intravenous antibiotics, which would otherwise mean that patients would need to remain in hospital.

There was a planned nurse led non-invasive ventilation service due to be introduced on Locke ward. Staff had completed training and changes to the ward infrastructure had been made to accommodate this service. The service was originally scheduled to start in September 2016, but this had not yet taken place. The matron reported that the service was due to launch in January 2018.

Fleming ward and Saunders ward had been reconfigured from longer stay medical wards in November 2017 and had changed to a Medical Assessment Unit (MAU), and a short stay ward to assist patient flow in the hospital. However, it was too early to establish whether this had been successful as the new system was still being embedded. The service planned for all patients to pass through the MAU or short stay ward before being admitted to a medical ward. However, at the time of the inspection both wards being utilised for longer stay patients due to pressures on the service.

A wide range of information was available to patients and their families on large notice boards and leaflet racks on the wards and visitor waiting areas. The notice boards were clearly visible and accessible for patients and families.

All medical wards were single gender compliant and no mixed gender breaches had been reported by the trust on medical wards.

Wards had individual dementia champions to help patients and relatives in managing their care. The service had also transformed an existing medicine ward into a specific frailty ward, which incorporated specially designed environment for older patients and specially designed patient centred care.

Wards had access to a dedicated nurse specialising in dementia and learning disabilities.
Average length of stay

Trust Level

From August 2016 to July 2017 the average length of stay for medical elective patients at the trust was 3.4 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 6.6 days, which is similar to the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Elective Average Length of Stay – Trust Level

Non-Elective Average Length of Stay – Trust Level
From August 2016 to July 2017, the average length of stay for medical elective patients at Princess Alexandra Hospital was 3.4 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 6.6 days, which is similar to England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Meeting people’s individual needs**

The hospital had specialist nurses in place to support the care of patients with complex needs. These included a specialist falls nurse, a learning disability nurse and a dementia lead nurse.

The hospital had “This is me’ booklets which family members could complete to give staff information on the needs and preferences of patients living with dementia. We saw one booklet, which had been completed by a patient’s family.

All wards were wheelchair accessible. The trust offered all leaflets in braille or large print on request. The trust also had access British sign language interpreters on request.

The trust used ‘health passports’ which were designed to communicate the health and social care needs of people with learning difficulties to doctors, nurses and other healthcare professionals. This passport gave detailed information in relation to patient’s preferences of care, family, and social circumstances.

There was an interpretation service available for patients and their families who did not speak English as their first language. Staff knew how to access the translation service.

The service had access to an intermediate care team to assist in discharge of patients and planning ongoing recovery.

Senior nursing staff and senior discharge coordinators facilitated complex patient discharges.

The trust complied with the Accessible Information Standard by asking people if they had any information or communication needs, recording and highlighting those needs clearly in the patients’ notes, and sharing relevant information with other NHS providers and local authorities when they had consent to do so. From 1st August 2016, all organisations that provide NHS care
and/or publicly funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

The service used dementia friendly clocks on older people’s wards in the hospital and red trays were used for patients’ meals to support patients with dementia. Wards for patients living with dementia used contrasting colours, for example around doorways, which can be used to help people with sight loss and dementia to identify key features and rooms.

Staff ensured call bells were within reach of patients and we observed call bells being answered in a timely manner by staff in the wards.

**Access and flow**

Patients were usually admitted to the medical wards from the emergency department (ED), the short stay medical ward (Saunders ward) or via the MAU. Patients could also be admitted to the MAU by their GP.

The trust had implemented an Emergency Patient Flow Escalation Policy, which was issued in July 2017 and was due for review in July 2019. One of the policy objectives is to improve the quality of care received by patients, reducing any adverse events by making sure that patients are cared for in specialty specific ward. The process and principles of good patient flow included “Optimisation of patient placement - managing the flow of patients to the right ward, first time every time.”

The trust monitored the number of discharge of patients taking place at night. The trust provided the following data for the number of discharges between 10pm and 8am for the reporting period 1 June 2017 to 31 December 2017; June – 28, July - 30, August - 43, September - 32, October - 40, November - 32, December – 22. However, the trust informed us that the medicine health care group are aware that ward teams are electronically discharging patients out of hours during quieter periods and not always correcting the time at which the patient was actually discharged. The trust was addressing these data quality issues.

Saunders ward was designed to take patients from the emergency department or the medical assessment unit (MAU) for a maximum of 72 hours for assessment. However, staff told us patients regularly stayed on the ward longer than 72 hours. At the time of our inspection, Saunders ward had only been used as a short stay unit for four weeks, so it was not possible to determine if the new system was positively impacting on access and flow.

Medical wards used the “red2green” system to help the flow of patients through to discharge. This was an initiative launched by NHS Improvement, which aimed to reduce wasted time within a patient journey where no interventions occurred and they received little benefit from remaining in an acute hospital. By using this visual management system, this supported meaningful admission and assisted the progress towards the patients end goal of discharge. Staff told us this had really helped in moving a patient journey along and ensured they did not waste patients’ time by keeping them in hospital longer than necessary.
Staff discussed patients’ discharge dates at daily ward rounds and multi-disciplinary team (MDT) meetings in the presence of social services, the discharge coordinator, physiotherapists and occupational therapists. This was to ensure those patients who were medically fit for discharge could be prioritised to leave the hospital.

Bed occupancy issues were regularly discussed at team meetings and were highlighted as a concern by all staff groups during our inspection. The trust also held a daily bed meeting, which was used to discuss capacity, patient transfers and planned discharges for that day.

Staff raised concerns to us during the inspection that patients were still moving beds too frequently at night and were being discharged too late into the evening.

Nursing staff told us the main reasons for delayed transfer of care (DTOC) was difficulties in arranging care packages and placements in care settings outside the hospital.

Discharge coordinators were based on each ward. The discharge coordinator liaised with external organisations such as care homes and agencies to speed up and coordinate the discharge process. Nursing staff and discharge coordinators both told us the role was working well. Discharge planning began on admission into the hospital. Discharge coordinators were tasked with liaising with partner agencies to facilitate an efficient discharge of patients.

Nursing staff arranged for patients awaiting discharge to be cared for in the discharge lounge. The discharge lounge had chairs for patients and could access beds for those patients who were unable to sit in a chair.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The trust started the reporting period in September 2016 with a RTT rate of 67%, below the England average of 89%. The trust has shown a trend of improvement immediately after this, bringing performance to a similar position to the England average.

Despite this, the trust’s performance has declined over the 12-month period. It was somewhat stable from September 2016 to January 2017 where the trust varied around the England average. From February 2017 performance dips below the England average, from that point performance fluctuates but remains below the average. Both April and August 2017 have zero patients reported; this may indicate a breakdown in data collection at those points.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>0%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0%</td>
<td>93.4%</td>
</tr>
</tbody>
</table>

There are no entries recorded within the data for the specialities ranked at 0%. These should not be taken as indicators of poor performance.

(Source: NHS England)

Referral to treatment times remained below the England average as at the previous inspection.

Learning from complaints and concerns

The trust had a policy in place on the process of dealing with complaints. The policy clearly outlined how complaints should be investigated and by whom and expected time limits for response. Staff could access the policy on through the trust intranet.

Complaints information was clearly displayed in staff room areas. We saw that feedback from complaints was shared. Staff confirmed that learning from complaints was shared at one to ones and team meetings.

Senior nursing staff received additional training in the complaints handling process.

The Patient Advice and Liaison Service (PALS) was easily accessible within the hospital and information on how to contact PALS was available in all ward areas. Information on how to make formal complaint was also displayed in ward areas for patients and relatives.

Learning and feedback from a complaint resulting from an incident that occurred on Jon Snow ward was shared on across all medical wards on staff notice boards. The incident related to a patient fall while being hoisted by staff. Further training had also been provided to staff for moving and handling patients.

Patients and relatives we spoke with were aware of how to raise concerns or make a formal complaint.

Summary of complaints

From August 2016 to July 2017, there had been 67 complaints about medical care. The trust took an average of 63 days to investigate and close complaints; this was in line with their complaints policy, which stated that complaints should meet the national target of 180 days with all deadlines
for completion agreed with the individual complainants.

The most common complaint themes reported in medicine were patient care including nutrition and hydration with 24 complaints, followed by admission, discharge and transfer arrangements (excluding delayed discharge due to absence of care package) with 14 and communication themes also with 14 complaints.

Thirty complaints were against medical staff whereas 33 were reported against nursing staff, and 55 complaints were reclosed after their initial closure.

- Between August 2016 Locke ward: 13 (six of which were around patient care including nutrition and hydration)
- Ray ward: 12 (five of which were around admission, discharge and transfer arrangements (excluding delayed discharge due to absence of care package))
- Henry Moore ward: 11 (mix of complaint themes communications, patient cares and privacy, dignity and wellbeing)

and July 2017 most complaints were made against the following wards..

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The medical service was part of the medicine and patient at home health care group, which operated a triumvirate management system, with an associate clinical director, associate director of nursing, and associate director of operations who worked together to run the health care group. Service matrons, clinical leads for each medical specialty and service managers supported the triumvirate management team.

The leadership structure was well established and there were clearly defined and visible leadership roles across the medicine and patient @ home health care group. Without exception, leaders demonstrated to us they had the skills, knowledge, experience and integrity required to undertake their roles and all had an understanding of, and were focussed on the challenges within their service. Challenges identified by the leadership team reflected the concerns we had identified throughout our inspection.

The trust had a whistleblowing policy and named freedom to speak up guardian. Freedom to speak up guardians work alongside trust leadership teams to support staff to speak up, ensure a culture of speaking up is instilled, and ensure processes are effective and improved. Staff knew how to raise a whistleblowing concern and felt they would receive support from their freedom so speak up guardian if required.

Both nursing and medical staff consistently reported they had good relationships with service leads and described managers as approachable and supportive.

Wards and departments were led by band seven ward managers or team leaders and were supported by band six nurses.

Front line staff reported good leadership across the organisation including, from their line managers and matrons of the service. Nursing staff felt ward sisters, matrons and heads of
nursing were approachable and visible and provided a good level of support. We observed matrons in the clinical areas throughout our inspection.

Ward managers told us they felt supported by their matrons and they were committed to delivering a high quality service. All ward managers we spoke with told us they were proud of their team and felt morale across the medical directorate was improving.

Ward managers and consultant staff were visible throughout the clinical areas, and were closely involved in the day-to-day management of care and services.

The medical health care group had a dementia and learning difficulties lead nurse who was responsible for implementing the dementia care strategy and acted as a point of contact and advice for staff treating patients.

**Vision and strategy**

The trust’s vision and values were clearly displayed in staff and public areas in the department. The vision was to be an excellent provider of integrated acute care services. The values were that staff were respectful, caring, responsible and committed when carrying out their role.

The trust board launched a quality improvement project in September 2017 titled ‘Your future, our hospital’. The Deputy Director of the Quality First Team was leading the project on five specific areas, known as the ‘Five Ps’: patients, people, performance, places and pounds. The Five P plans involve staff working within their individual teams and departments to inform a Trust-wide plan. Staff had attended an ‘Event in a Tent’ day where the new strategy and project and had been discussed. Staff on all wards were aware of the new project and felt involved in its implementation.

There was no formal vision for the medical directorate. However, there was a clear strategy for the medical division to improve patient flow through the implementation of the new short stay ward, MAU and frailty ward, which had all been implemented in the period leading up to the inspection.

All the staff we spoke with knew the hospital wide values and told us they felt staff embodied them.

Each medical ward had a specific vision, for example, the vision for Harold ward was to, “Be the best ward in the hospital”. Staff told us they were involved in the developing the vision for the individual wards.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff. It was evident that managers from the leadership team down to ward managers were very proud of their teams in the way in which they spoke of them and celebrated their successes.

We found an open, honest and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice.

All the nursing staff we spoke with were positive about their relationship with their immediate team and line manager.

Staff told us there had been a positive change in the culture the hospital since the appointment of the new chief executive officer (CEO).

Nursing staff told us the culture on medical wards was positive and that doctors were helpful and supportive.
We observed a culture of multidisciplinary team working on the wards we inspected. Therapy staff and discharge coordinators felt included by nursing and medical staff in decisions related to patient care, treatment and discharge planning. All staff worked together to meet the needs of patients on the wards.

Junior doctors told us they felt supported by senior medical staff and felt they had sufficient assistance for their learning and development.

All staff we spoke with told us they felt the medicine health group was a supportive and interesting place to work. We saw staff interacted in a supportive and friendly way within the department to ensure safety and efficiency for patient care.

We observed a positive and calm attitude within the team, even during very busy periods. Nurses felt that senior staff gave them clear leadership and feedback on their personal and team performance on a regular basis and made them feel valued as part of the team.

**Governance**

There were effective structures, processes and systems of accountability in place to support the delivery of the trust’s strategy and good quality, sustainable services.

There was an embedded governance structure within medical services. The medical health group and patient safety and quality group meeting were held monthly which reported into to the trust committee on patient safety.

There were measures in place for ward-based risks to be escalated to the trust board. Ward managers completed monthly reports, which included the ward based risk register. The risk profile for the wards were managed by the medical services leadership and reported in to the trust board meetings, which was evidenced in minutes.

Weekly health care group governance meetings were held that linked in with trust-wide clinical effectiveness committee meetings.

The ward nurse in charge led weekly ward team meetings. The Matron led nurse in charge meetings and attended meetings with the head of nursing.

The service had a named sepsis lead who was responsible for organising training, monitoring and reporting of sepsis within the trust. Sepsis results were reported into the patient safety and quality group and any issues were escalated to the trust board.

**Management of risk, issues and performance**

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions.

The trust had a major incident plan in place. This was regularly updated and available on the trust intranet page. Cards for actions of the medical staff, which were part of the plan, were available on each ward.
The trust risk register for medical wards was reviewed and a summary of the register submitted. The risk register contained concerns around staffing levels, medicines, and the hospital environment. The risks that were on the register had control measures in place and a review date.

The medical wards had systems in place for managing current performance. Nursing staff reviewed performance monthly via the quality indicators audit results including hand hygiene, falls, and infection prevention and control (IPC).

Nursing staff told us about their local worry list, which included the shortage of nursing staff. All the concerns nursing staff identified had been recorded on the trust board assurance framework with mitigating actions, named lead and review dates.

Medical services had a risk register with defined actions to mitigate the severity of the risk. These were reviewed at regular intervals.

Each ward also had a specific risk register that was on display in staff rooms showing the top three risks on the ward. Most wards listed staffing as the top risk with the following controls in place; ongoing recruitment within the medicine healthcare group, international recruitments and recruitment open days. This was an improvement from our previous inspection, because there was evidence of identified risks to the service, and mitigation and actions had been taken to minimise the risk.

Staff conducted monthly audits on the wards to monitor quality and patient safety. These audits ranged from patient records, which were monitored to assess compliance in areas of risk assessment and escalation of a deteriorating patient to the hand hygiene audit. These audits formed part of ward monthly reports that were completed by the ward managers.

The trust provided mental health nurse cover 24 hours a day, seven days a week for adults. Responsibilities of the mental health nurse included supporting other members of staff when treating patients with mental health needs.

**Information management**

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via computer based and paper patient records and the staff intranet.

The trust used electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

**Engagement**

Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways including face-to-face, email, and through staff bulletin boards.

The trust CEO invited all staff to attend a weekly executive team briefing held in the hospital canteen. The CEO encouraged all staff to raise any questions or concerns directly to them. We attended one of these meetings at our well-led inspection. The meeting was very well attended and was used as a platform for the senior leadership team to share any relevant updates as well as giving staff the opportunity to raise any concerns or share any updates from their perspective.
The trust organised an ‘Event in a Tent’ day, which was a day dedicated to staff preparation for the CQC inspection during which they brought in actors to demonstrate good practice, facilitate discussions to allow staff to share their ideas for how to share information with the inspectors.

The CEO sent weekly hospital wide staff updates and had a dedicated email address so staff could contact them directly.

The Trust launched a staff recognition scheme in 2016 called the Daisy Chain. Recipients of the Daisy Chain Badge are those colleagues who go the extra mile for patients or colleagues.

**Learning, continuous improvement and innovation**

The trust was piloting a pharmacy ward project, which involved pharmacy staff working more closely with ward staff to ensure problems were identified, medicines were available and to allow more timely discharges. Nursing staff reported this pilot was working well on the two medicine wards it was being piloted. Nursing staff reported that they believe the system would lead to safer and more efficient prescribing.

The trust had taken control of the running of the ‘Patient at Home’ service. Patient at Home is a free service provided by the trust and offered medical treatment to patients in their own home. The team consisted of doctors, nurses and allied health care professionals who were available 24 hours a day, seven days a week. The vision for the team was to work to ensure the right person treats patients in the right place, at the right time. The aim of the service was also to relieve pressure on beds in the hospital by allowing patients that would otherwise be in hospital be treated in their own home while still receiving acute care.

The trust had introduced electronic recording of patient observations since our last inspection. Nursing staff completing patient observations on hand held computer tablets. Staff told us this system was an improvement as it saved time and reduced errors.

The medical service had introduced the Red2Green initiative across medical wards, which was designed to help facilitate a safer discharge from hospital for patients.

Since our last inspection, the trust had introduced the ‘Talk to Me’ programme. This was an innovation developed by the Medicine Health Care Group and was aimed at supporting learning from complaints and incidents, that had been rolled out across the trust. This initiative also aimed to improve communication to understand the impact of individuals’ leadership on both patients and staff.

**Surgery**

**Facts and data about this service**

The Princess Alexandra NHS Trust provides an acute surgical service serving the local population of Hertfordshire and Essex. Areas of speciality include general surgery, including vascular, urology and breast surgery, head & neck, including ophthalmology, oral and ear, nose and throat and trauma & orthopaedics.

There had been some reconfiguration of the surgical service in the 12 months prior to our inspection and at the time of our inspection the service consisted of:
• Three inpatient surgical wards; Henry Moore with 19 (capacity for 22) beds which is used for elective orthopaedic admissions only, and Tye Green and Penn wards with 29 and 28 beds respectively which are used for emergency admissions and step down care from the Intensive Care Unit. We did not inspect the gynaecology surgical ward at his time.

• The Alexandra Day Stay Unit (ADSU) which was located in a separate building and had four operating theatres and 27 beds including a separate six bedded paediatric area.

• The same day admission unit on Nettleswell.

• Eight operating theatres in the main operating suite (and one obstetric theatre located in the obstetric department but not inspected on this occasion)

• The Post-Operative Anaesthetic Care Unit (PACU) with 11 recovery spaces including one dedicated paediatric space.

• A surgical assessment unit comprising two trolley spaces, one examination/treatment room and seven chair spaces was in the process of opening on the last day of inspection on Melvin ward.

• The trust also offered an acute pain service, specialist nurses support and had sterile services on site.

The previous inspection in 2015 rated the service as overall requires improvement with safe rated as inadequate. The main concerns were; extended periods of time patients spent in PACU, referral to treatment times standards not being met, inconsistent discharge planning and high numbers of out of hours transfers, instability in senior management and lack of attention to policies and procedures.

During this inspection, we visited the wards, operating theatres, admission and day stay unit and the PACU. We spoke with 49 staff, including medical, nursing and administrative staff and eight patients and relatives. We reviewed policies and information supplied by the trust and 19 patient and prescription records.

The trust had 17,248 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 4,571 cases (26.5 %), 8,879 (51.4 %) were day case, and the remaining 3,798 (22%) were elective.

(Source: Hospital Episode Statistics)

The trust has eight main operating theatres covering Head & Neck, including Ophthalmology; Urology; General Surgery, including Vascular and Breast surgery; Trauma & Orthopaedics; Surgical Pre-Assessment; Post Anaesthetic Care Unit (PACU); and Acute Pain services across two sites. The trust has four surgical wards. Areas of speciality include: Head & Neck, including Ophthalmology; Urology; General Surgery, including Vascular and Breast surgery; Trauma & Orthopaedics; Surgical Pre-Assessment; Post Anaesthetic Care Unit (PACU); and Acute Pain services.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)
Is the service safe?

**Mandatory training**

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory courses for July 2017 for medical/dental and nursing/midwifery staff in surgical care is shown below:

**Mandatory Training Completion by module – Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>58</td>
<td>141</td>
<td>41%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>88</td>
<td>149</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>68</td>
<td>149</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>72</td>
<td>149</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>44</td>
<td>120</td>
<td>37%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Mandatory Training Completion by module – Nursing and Midwifery Staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire</td>
<td>47</td>
<td>55</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>105</td>
<td>113</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>49</td>
<td>55</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>54</td>
<td>67</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>20</td>
<td>22</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Mandatory training rates for staff did not meet the trusts target of 95%. Medical staff training rates were notably lower than expected with 41% on fire safety and 37% on infection control.

Staff participated in a range of mandatory training as seen in the tables above, delivered both face to face and via electronic learning. Staff commented that they were given time to do their training and could claim time owing back if they did this in their own time at home.

Nursing staff we spoke with were up to date with mandatory training and the ward managers had good oversight of staff who still required training. Whilst on inspection we reviewed the nurse training records, which showed that 100% of Henry Moore ward staff, 85% of Penn ward staff and 100% of Tye Green staff had completed mandatory training in the period December 2016 to November 2017. In theatres, the post-operative anaesthetic unit (PACU), Netteswell, and the Alexandra Day Stay Unit (ADSU) the figures were 95%, 100% and 94% respectively. Where the figures were below target we saw evidence of booked dates or staff absence as a reason. Nurse mandatory training rates and senior nurse staff oversight had improved since our last inspection.

The medical staff mandatory training was lower than the trust’s target of 95%, significantly lower in some subjects. The figures provided by the trust post inspection showed 53.3% had completed their training. The speciality with the highest completion rate was the ophthalmology staff with 90% completion rates and orthopaedic medical staff were the lowest with 42.5% completion rates.

Poor compliance was discussed with the clinical director. Participation in mandatory training is part of the General Medical Council (GMC) requirements for five yearly revalidation of medical staff. Revalidation occurs every four months at the GMC and the clinical director was confident that the medical staff would be no more than three months out of date at any time during the year.

**Safeguarding**

Safeguarding formed part of mandatory training for clinical staff working within the surgical directorate and 100% of nursing staff had completed level two adult and children’s safeguarding training. This was a significant improvement since our last inspection.

Nursing staff safeguarding level three training for adults or children was low with only the most senior nurses having level three training within the theatres, and the PACU despite them treating children on a regular basis. For the period June-November 2017, they performed 639 paediatric surgeries, which were 8.2% of all surgeries. This was discussed with senior nursing staff and we were supplied with information following the inspection that showed 73% of PACU staff and 24% of theatre staff had undertaken level three children’s safeguarding training in the weeks following our inspection. The remaining staff all had dates booked within the following three months.

The medical staff safeguarding training was not as complete (see table below). Information provided following the inspection demonstrated that 62.2% of the total medical staff had completed safeguarding level three training for children, which included only 12.5% of the orthopaedic staff. The Intercollegiate Document Safeguarding children and young people: roles and competences for health care staff Third edition: March 2014 recommends that ‘Those with a mixed caseload (adults and children) should be able to demonstrate a minimum of level two and be working towards attainment of level three core knowledge, skill and competence’.

Staff had electronic access to adult and children’s safeguarding policies which were ratified, and within review date. The policies reflected national guidance and provided information on referral pathways and local contacts. All staff we spoke with understood their safeguarding responsibilities and were able to demonstrate awareness of safeguarding procedures and how to recognise those at risk. This included knowledgeable about female genital mutilation and child sexual exploitation.
There were safeguarding flowcharts available for staff to follow, which gave clear guidance on actions and staff knew the safeguarding leads name and commented that they were supported with any concerns they had.

The trust used alerts on the electronic patient records system identify patients at risk of suicide or self-harm and there was access to a mental health team for advice.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of adult safeguarding training. And a 90% target for completion of safeguarding level 2 training.

A breakdown of compliance for safeguarding courses for July 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

### Safeguarding Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults level 2</td>
<td>51</td>
<td>126</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children level 2</td>
<td>30</td>
<td>66</td>
<td>45%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical & dental staff failed to meet the trust target for both safeguarding modules, safeguarding adults level 2 had the lowest completion rate with 40%.

### Safeguarding Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults level 1</td>
<td>0</td>
<td>11</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults level 2</td>
<td>22</td>
<td>22</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children level 2</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing & midwifery staff exceeded the trust target of for both modules, the trust however did not meet the target for Safeguarding Adults level 1 with a completion rate of 0%, however, this was not significant given that 100% of staff had achieved level 2 adult safeguarding training.

(Source: Trust Provider Information Request P18)
Cleanliness, infection control and hygiene

During the period December 2016 to February 2017 there were five surgical site infections reported following orthopaedic procedures for joint replacement.

The trust suspended these procedures in March 2017 for a period of time to allow an investigation to take place. The investigation found no common cause for the infections or common bacteria responsible however; it did identify some best practice actions, which have been undertaken.

A Scrutiny Panel (internal & external stakeholders attended) was held to ensure that appropriate actions had been taken to prevent re-occurrence. There have been no further infections reported in orthopaedic surgery since April 2017. The trust continues to implement polygamous chain reaction (PCR) technology, taking swabs from orthopaedic joint replacement wounds whilst in theatre to ensure that all possible measures are in place to preventative further infections.

Patients were only admitted to Henry Moore ward, the designated orthopaedic joint replacement ward, if they have been screened for meticillin-resistant Staphylococcus aureus, (MRSA, which is a bacteria often found on the skin, which is difficult to treat).

Formal sepsis teaching was included on medical and nursing induction to ensure staff were aware of the trust infection control and sepsis guidelines.

Sepsis update presentations were included at all senior forums and Patient Safety & Quality Committees to ensure oversight of infection rates.

The service had infection prevention and control (IPC) link nurses and resource folders in all of the surgical wards and departments for staff to refer to.

All of the clinical areas we visited appeared visibly clean although there were scuff marks on the doors and floors of the theatre suite. This meant that it was difficult to ensure that doors and floors were clean and flooring was noted as a concern on the directorate risk register. Senior staff told us that the clinical theatre staff were responsible for cleaning the theatre areas including floors.

We inspected items for use in theatres. There were several stools and a warming pad in theatres with torn outer covering which represented an infection risk as it made them difficult to keep clean. We discussed this with the senior nurse who confirmed that this had been noted and replacement stools and warming mattress were on order. We received information following the inspection indicating that warming mattresses had been ordered in January 2017 and one stool in November and three in December (the day it was brought to staff’s attention).

Hand sanitiser was available at ward entrances with signs to remind staff and visitors to wash their hands on entering and leaving the wards.

Daily cleaning checklists were displayed on the doors to the ward side rooms and the four and six bedded wards on Tye Green and Henry Moore wards. These were signed and dated by staff and there was a record on all of the clinical areas of the cleaning checklists, which provided oversight of cleanliness to help reduce the risk of infection.

Nursing and medical staff adhered to the trust ‘bare below the elbows’ uniform policy which allowed appropriate hand hygiene to be performed. We observed both nursing and medical staff washing their hands between patient contacts as per the World Health Organisation’s “Five Moments of Hand Hygiene” guidance.

We observed theatre staff scrubbing surgical procedures and, following IPC guidelines. The theatre and PACU staff used white coats over their theatre scrubs when leaving the department. This was in line with trust policy.
Nursing staff on the wards had access to and wore personal protective equipment (PPE) such as aprons and gloves when providing care to help prevent the spread of infection.

The surgical directorate monitored hand hygiene compliance monthly. Between June and December 2017, compliance ranged between 88.8% and 100%.

Staff labelled equipment with dated ‘I am clean’ stickers following cleaning which assured staff that the equipment was clean and ready to use.

The nursing staff used an ‘invasive lines care bundle’ to help reduce infection risk for those patients with peripheral intravenous therapy lines and catheters. The three forms we reviewed showed they were being used effectively.

**Environment and equipment**

The design, maintenance and use of facilities were adequate to meet the needs of patients although the main theatre suite was old and displayed signs of wear and tear with the doors to the theatre areas being marked and pitted in places and the floor areas being scuffed and scratched in places. This was noted in the IPC Annual report produced in 2017 with a provision of securing funding for replacement floors.

The lead aprons used for staff protection during x-rays in the theatre corridors were not hung up tidily and we noted that some were folded, which could potentially damage the lead lining and render the apron ineffective, or draped on the floor, which could represent an infection risk. We related our concerns to the senior nurse and information supplied by the trust following the inspection showed that the service audited the aprons in May 2017 and identified those that were damaged. However, we were not assured that this was a regular occurrence for the protection of staff and patients.

At the entrance to each surgical ward there was a board showing pertinent information about each ward and the nursing staff on duty. This included information such as ward visiting times, ward pledge, champions, safety dashboard information, performance data and compliments and complaints. This was updated regularly (staffing daily) and provided patients and visitors with the most recent information about the ward.

Staff managed clinical waste in line with trust policy. Sharps were disposed of safely in correctly assembled and dated sharps disposal boxes.

Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins were regularly emptied by domestic staff during our inspection.

The surgical wards used fabric curtains around patient bedsides and we were informed that these were changed on a regular basis although the nursing staff were not aware how often this occurred. Staff could request a change of curtains if they became soiled.

Surgical and anaesthetic equipment was available and checked in line with professional guidance such as the Association of Anaesthetists of Great Britain & Ireland (AAGBI) ‘pre-use check to ensure the correct functioning of anaesthetic equipment’ prior to surgical procedures.

We reviewed a range of electrical equipment (27 pieces) across the wards and theatre areas. These included hoists, blood pressure monitors and specialist theatre equipment. All items carried portable electrical appliance testing (PAT) stickers to show that the equipment had been tested for electrical safety within the last 12 months.
All areas and wards had resuscitation equipment stored in and on trolleys in accessible locations. The equipment within the trolleys had been standardised across the trust and was in sealed plastic bags, which meant that it was clean and ready to use and staff were assured that nothing had been removed.

Staff checked the contents of the trolleys weekly including use by dates and the trolleys were locked with a security tag and checked daily. We reviewed records of the weekly and daily checks in all areas visited and found them to be consistent from August to December 2017 apart from Henry Moore ward where they were only available for the previous week, as the ward had been moved from another location.

Review of the of the difficult intubation trolley in theatres showed that all relevant items were available and there had been an improvement in the checking since the last inspection with checks being consistently done on a daily basis.

**Assessing and responding to patient risk**

Patients attended a pre-operative assessment clinic in the weeks prior to surgery where their general health and suitability for surgery were assessed. Any required investigations were performed at this time. We reviewed five sets of notes, which showed that the appropriate risks and concerns were addressed. Any patient identified as a potential anaesthetic risk or other concern was reviewed by an anaesthetist.

Staff completed standard risk assessment tools on admission and used specific tools for pressure ulcer risk, moving and handling, bed rails risk, nutrition, falls, and dementia screening. The records that we reviewed showed that risks had been updated as patient conditions changed ensuring the appropriate action to reduce risk.

Prior to surgical procedures staff used the World Health Organisation (WHO) “Surgical Safety Checklist and five steps to safer surgery”. We observed this being done prior to two surgical procedures and noted that on one occasion the wrong side prosthesis was identified during the process. Theatre staff had introduced a six step ‘Pause for Prosthesis’ process following a previous incident when the wrong implant was used. The steps involved all of the surgical team verbally confirming the implant recorded on the theatre whiteboard and assured staff that the right implant was available. The staff took the appropriate action to resolve before continuing with the checklist. This was good practice. It was however noted however that not all surgical staff were present at the start of the check with a medical staff member arriving halfway through the checklist, which is not in line with best practice.

The service undertook paper audits of the World Health Organisation (WHO) “Surgical Safety Checklist and five steps to safer surgery” and information supplied by the trust showed between 99% and 100% compliance between June and November 2017. However, our observations showed that whilst the staff followed the principals of the checklist, there were concerns about staff not being present that would potentially mean that their audit of compliance was not accurate. We raised this as a concern with the trust. The trust acknowledged their audit did not contain an observational element and only focused on the documentation of the WHO checklist. The Chief executive and the chief nurse of the trust acknowledged this concern and recognised the audit needed to introduce an observed element. The trust was going to implement an observed element to the audit.

Nursing staff on the wards had undertaken ANTS training (agents of nutrition and tissue viability). The training encompassed extended nutrition and pressure ulcer (PU) prevention and staff felt
that this had helped with the high number of days without avoidable PUs on the wards; 320 days on Tye Green and 670 days on Penn ward.

Nursing staff on the surgical wards used the national early warning score (NEWS) to assess, monitor and identify deteriorating patients. The NEWS was completed on hand held tablets and any NEWS of five or above immediately flagged to the critical care outreach team (CCOT). The tablet also directed the user to escalation actions in the case of deteriorating patients. The five records we reviewed showed that staff routinely completed NEWS and alerted senior staff and medical staff to deteriorating patients.

There was a sepsis screening pathway following the Sepsis six protocol in use on the surgical wards which gave staff clear direction on escalating patients where there was a suspected infection. The Sepsis Six care bundle outlines six actions, to be undertaken within one hour, for early management of sepsis. We saw six patient records where this was in use and spoke to staff from the CCOT who confirmed that the pathway and NEWS worked well in identifying patients in a timely way.

Nursing staff commented that junior medical staff were not always responsive when called regarding concerns about patients and that they often had to escalate to senior medical staff for review when there were concerns.

Staff in PACU received immediate life support (Level 3) training and compliance was at 91.6% against a target of 95%. There were no paediatric trained staff working in the PACU and 86% of staff of staff were trained in paediatric immediate life support. We requested but were not supplied with numbers of staff trained to advance adult or paediatric life support. Following our inspection we were supplied with information which showed that all remaining PACU and all anaesthetic staff were booked onto paediatric immediate life support training within the next three months.

**Nurse staffing**

Ward managers used the Shelford Safer Nursing Care Acuity Tool to plan staffing requirements according to patient need.

Shift rotas were planned two months in advance. Staff had access via a mobile app, an online portal and the hard copy paper record kept on the ward, to see the shifts they had been booked for. Agency and bank staff were booked onto the rota once the substantive staff rota had been agreed.

Daily shift reports were completed on each ward, which documented whether shift numbers and workload needs were met for day and night shifts. These numbers were fed into a programme, which produced monthly shift reports for oversight of nurse staffing.

The senior nurses held a twice-daily meeting to address staff needs across the surgical wards. This sometimes involved moving staff between the surgical wards. This was not popular with staff although they did acknowledge that it was necessary to ensure safety for patients.

Staff we spoke with said that staffing had improved and although it was still their biggest concern they could manage patient acuity with the addition of regular agency staff. Junior staff on Penn ward were concerned about the frequent late shift finishes and felt that morale was low and this was compounded by a perception of poor senior nurse support above the grade of the ward manager.
Staff in the PACU reported that they had concerns when patients were transferred back to them from the ADSU in the evening until discharge home, when they generally had less staff available (usually staffed for emergency surgery only). They had raised concerns with senior staff although not completed incident report forms. This was being reviewed in the near future with a proposal to increase the number of hours the ADSU opened but remained a concern.

The trust has reported their staffing numbers below for the period April 2017 to July 2017.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Midwifery staff</td>
<td>189.35</td>
<td>131.97</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between August and November 2017 the fill rates for nursing staff on the surgical wards ranged between 81% and 85% for registered nurses (RNs) and between 65.5% and 86.7% for healthcare assistants (HCAs). This meant that on average RN staffing was at 86.8% and HCA was 77.1% of total staff required. Staff told us that they often worked longer than their shift hours in order to assist their colleagues and to complete paperwork that they did not have a chance to do during their shift. We observed this in action with a night duty nurse who was still on the ward two hours after their shift ended.

Vacancy rates

Staffing had improved since the last inspection but there were still significant vacancies and recruitment was a recognised risk on the trusts risk register. There was a rolling recruitment programme for nurses

All areas we visited had nurse vacancies with Tye Green having 31% registered nurse (RN) and 15.8% health care assistant vacancies, Henry Moore with 19% RN and Penn ward with 23% RN vacancies.

The wards reported nurse vacancies on the whiteboard at the entrance to each ward and which staff were on duty. This ensured that both patients and visitors were informed of the current staff available.

From August 2016 to July 2017, The Princess Alexandra Hospital reported a vacancy rate of 0.2% in surgical care.

Turnover rates

From August 2016 to July 2017, The Princess Alexandra Hospital reported a turnover rate of 22.8% amongst nursing staff in surgical care. This is not in line with the trust target of 11%. Despite this, the monthly average is 1.9% with spikes in turnover in August 2016, and again in December 2016 and January 2017.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates

From August 2016 to July 2017, The Princess Alexandra Hospital reported an annual sickness rate of 4.2% amongst nursing staff in surgical care. This is not in line with the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

The surgical wards and theatres used bank and agency nursing staff to fill shifts. Between August and December 2017, agency staff covered 494 nursing shifts with the highest number (202) on Penn ward and the lowest number (12) in theatres.

There were induction processes for staff who had not worked on the ward before and induction records were kept on the wards with copies given to the agency staff for competencies such as the trust’s intravenous drug administration for their own records and to show other ward staff.

Staff commented that where possible they requested the same agency staff to ensure continuity of care as on some night shifts there might be only one substantive ward nurse on duty.

The trust told us that their total shifts for August 2016 to July 2017 was a total of 9,207 for surgery for both qualified and nursing assistant staff, the trust used bank staff for a total of 4,289 shifts (45%) and agency staff to cover a total of 758 shifts (8%) and they did not have any cover for a total of 1,475 shifts.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust reported their medical staffing numbers for surgery below for July 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>180.11</td>
<td>156.25</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Surgical medical staff worked on a rota, which provided medical cover to the wards 24 hours a day, seven days per week. Surgical consultant availability was Monday to Friday 8am to 5pm and junior staff contacted senior medical colleagues for advice and support by telephone when required at night. There was out of hours on call support from a consultant on a rota basis if required.

Anaesthetic medical staff cover was 8am 8.30pm Monday to Friday and 8am to 2pm at weekends with the rest of the time via an on call rota.

Medical staff performed daily ward rounds and there was a daily multidisciplinary discussion of each patient’s care and plans for discharge.

There was a medical outliers team which specifically reviewed medical (as opposed to surgical) patients who were ‘boarded’ on surgical wards daily.
Medical staffing had vacancies across the specialties with a dependence on locums to support services. Recruitment was undergoing with further human resources support to drive forward.

For the period August 2016 to November 2017, locum doctors of varying grades covered 1270 shifts. The speciality which used the most locum cover was general surgery with 657 shift covered by locum doctors.

**Vacancy rates**

From August 2016 to July 2017, The Princess Alexandra Hospital reported a vacancy rate of 10.2% in surgical care. The trust has not supplied data around staff groups at the time of production of this report.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From August 2016 to July 2017, The Princess Alexandra Hospital reported a turnover rate of 15.3% amongst medical staff in surgical care. This is not in line with the trust target of 11%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From August 2016 to July 2017, The Princess Alexandra Hospital reported an annual sickness rate of 4.2% amongst medical staff in surgical care. This is not in line with the trust target of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum usage**

The trust told us that their total shifts for August 2016 to July 2017 was a total of 19,410 for surgery for both medical locum and bank staff, the trust used bank staff for a total of 1,031 shifts (5%) and agency staff to cover a total of 4,391 shifts (23%).

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

From July 2017 to July 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.
Staffing skill mix for the whole time equivalent staff working at The Princess Alexandra Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>47%</td>
</tr>
<tr>
<td>Middle career</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Ward rounds were completed by a mixture of consultant, registrar and junior medical staff.

We observed junior medical staff being supported by senior colleagues and clinical teaching occurring at the bedside. Of the six junior medical staff we spoke with most were positive about their training experience and support from senior staff with two commenting that overall it had been good.

**Records**

Medical records were stored in trolleys behind the nurse’s stations on the surgical wards and the ADSU. The trolleys were unlocked but the nurses stations were not left unattended as there was a member of nursing or ward reception staff present. This meant that records were only accessible by authorised personnel.

We reviewed 12 patient records and nine medication records. The majority were clear and legible with the appropriate information recorded, although there were occasional omissions such as one weight not being recorded and one with allergies not recorded on the medication charts.

The emergency admission notes we reviewed showed that the patients were seen on the post take ward round within 12 hours of admission.

All records were signed and dated with the medical teams adding bleep numbers for contact or clarification. Pre-operative assessments were completed prior to attendance on the day of surgery and this identified those patients with high surgery risks and ensured that the appropriate investigations and plans were in place for the day of surgery.

Care plans and assessments on the wards were completed correctly and updated where needs had changed.

Staff used a ‘patient passport’ document for patients with additional needs. The passport provided staff with important additional information about a patient including any reasonable adjustments that were required to ensure care was tailored to individual needs.

Staff reported that they had good electronic access to diagnostic requests and test results for informing treatment decisions.
Medicines

Medicines were stored securely in locked cupboards in key code locked rooms accessible only by staff.

Two staff members checked controlled medications daily at the beginning of day and night shifts. Records showed this had been completed and signed with no gaps from September to November 2017.

Medication fridge temperatures were consistently recorded daily with high and low monitoring. There was evidence of temperatures outside of normal range being escalated and actions taken. For example, on Tye Green ward the medication fridge was located in a room without windows and the trust had installed an air con unit to keep the room within a specified temperature range. This had broken down before the inspection but they were using a portable unit to cool the room and measuring the ambient temperature daily, we were assured that there was good oversight and monitoring.

Penn ward was part of a pharmacy pilot project with full pharmacy support provided to the ward. This enabled prescriptions to be screened quickly and ‘to take away’ (TTA) medicines were ordered in advance to reduce delays in discharge.

A medicines management technician completed full medicine reconciliation for all patients within 24 hours of admission during weekdays, and within 72 hours at weekend admission on all the surgical wards.

Local microbiology protocols for the administration of antibiotics were available and staff were able to download a ‘PAH app’ on their mobile phones to access advice.

Prescriptions we saw showed that medications were given in a timely manner and the appropriate codes were used to indicate omissions.

We reviewed a range of medicines on the wards and theatre areas and found them to be within date except for on Tye Green ward where there were 3 bags of intravenous therapy (Gelofusin) that were out of date (expired 08/2017). These bags had been placed in a box of in date therapy and there was a risk that they could have been used if only the box details were checked. The senior nurse immediately removed them and the rest of the intravenous fluids were checked and found to be in date.

Incidents

The trust supplied information regarding incidents reported in the surgical division. The number of incidents reported for the surgical wards and services between June and December 2017 was 707. Of those 465 were reported as 'no harm', 139 'minor harm', 29 as 'moderate harm', 69 as 'near miss' and four as 'severe harm' and one death. The area with the highest rate of reporting was Tye Green ward (267) followed by Penn ward (172) and the lowest reported incidents was on Netteswell with four. The most commonly reported incident types were regarding the lack of suitably trained and skilled staff, followed by treatment or procedure and infection control concerns.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From October 2016 to September 2017, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2016 to September 2017.

Of these, the most common type of incident reported was

- Surgical/invasive procedure incident meeting SI criteria with three (27% of total incidents)
- HCAI/Infection control incident meeting SI criteria with two (18% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (18% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (18% of total incidents)
- Treatment delay meeting SI criteria with one (9% of total incidents)
- All other categories with one (9% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The serious surgical site infections that occurred within orthopaedics were thoroughly investigated and there was evidence of robust action being taken in stopping joint replacement surgery until the investigation had been concluded. There was no single factor or agent identified for the infections but the trust introduced an advanced system of swabbing wounds and checking for infection risk during the surgery. This system was continued on moving to a new ward to ensure accurate identification if further infections occurred. We reviewed two further SI reports and saw that they were done in line with best practice, identified root causes and factors and there was appropriate action planning with updates and in two cases a change in policy.

Incidents were reported on the trust wide electronic reporting system. All nursing staff we spoke with understood their responsibilities to raise concerns and report incidents.
Incidents were investigated by senior staff who were band six and above, and had completed root cause analysis (RCA) training.

Staff confirmed that they received feedback regarding incidents reported verbally, by e-mail and during team meetings. Learning from incidents was also displayed on the staff noticeboards. It was evident that learning from incidents had improved since the last inspection with staff having knowledge of recent incidents and learning relating to them.

Nursing staff held weekly RCA meetings for discussion of incidents and to share information and learning.

Staff that we spoke with understood their responsibilities in regard to duty of candour which 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. They were not all aware of the specific term but all understood it was about being open and transparent when went wrong.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Safety data was monitored and displayed on a white board at the entrance to the surgical wards. This included the number of days without avoidable pressure ulcers, catheter urinary tract infections and the number of falls.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, no falls with harm and nine new catheter urinary tract infections from October 2016 to October 2017 for surgery.

At the time of inspection Tye Green ward reported 670 days without an avoidable pressure ulcer and Penn ward 670 days.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Princess Alexandra Hospital NHS Trust
Total Falls
(0)

Total CUTIs
(9)

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The anaesthetics service had Anaesthesia Clinical Services Accreditation (ACSA). The scheme is a voluntary one for NHS and independent sector organisations that offers quality improvement through peer review.

The service used NICE National Institute for Health and Care Excellence (NICE) guidelines and guidance from authorities such as the Royal College of Surgeons to determine care and treatment. This had improved since the last inspection with updated guidance made available to staff electronically.

The Trust used web based software, to track status of NICE guidance. The Chief Medical Officer reviewed newly issued guidance on a monthly basis and allocated them to healthcare groups (HCGs) to review if applicable and assess compliance. Monthly compliance status reports were submitted to the Trust Patient Safety and Quality Group, chaired by the Chief Medical Officer, for review, assurance and any appropriate action / challenge.

Ward staff described the use of evidence based guidance that underpinned care for example in preoperative fasting guidelines, use of post-operative analgesia, when assessing nutritional status using the Malnutrition Universal Screening Tool (MUST), assessments for venous thromboelism (VTE), National Early Warning Score (NEWS) and visual infusion phlebitis (VIP) scores for central venous catheters and peripheral venous catheters as recommended by the Royal College of Nursing in Infusion Nursing standards of practice (INS 2011).

The trust had recently introduced a version of the ‘Golden Patient’ (GP) process to improve theatre productivity. The GP is a generally considered to be the pre-selected first patient on the following day trauma list who is medically fit with a clear surgical plan. The GP should have already been seen by an anaesthetist and be ready to be sent for by theatres early. This has been shown to improve operation start times and the trust had modified it for other surgical specialities to improve services and meet clinical targets more readily.

The surgical department had not yet introduced the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) but were in the process of doing so.
The surgical service participated in more than 12 national and internal audits which were ongoing at the time of inspection including: negative appendectomy rate, glaucoma NICE Quality Standards, and Quality of admission clerking for emergency adult general surgery and urology patients.

**Nutrition and hydration**

Fasting guidelines were in place to ensure patients were not deprived of food or fluids for longer than necessary prior to surgery. The surgery and anaesthetic team reviewed the operating order list at the start of the day during the team brief and Netteswell admissions unit (NAU) staff provided ‘Hydration cards’ to patients to inform the cut off time for drinking clear fluids prior to surgery. This meant that patients were not unnecessarily fasted for extended periods.

Medical staff routinely prescribed ‘as required’ anti-nausea and vomiting medication for post-operative patients to assist with side effects from surgery.

During admission patients nutritional status was assessed using the Malnutrition Universal Screening Tool (MUST). Any patient identified as malnourished or at risk of malnutrition was referred to the dietetic service.

Patients on the wards had access to drinking water via personal water jugs and we saw that these were refreshed regularly during the day.

Meal times were protected on all the surgical wards to enable staff availability to help patients with eating and drinking. Patient’s special dietary requirements were recorded on the bedside patient information boards to ensure that all staff were aware.

The bedside patient information boards identified patients with difficulties who required support and assistance with eating and drinking and red trays were used.

**Pain relief**

Pain relief was discussed at pre-operative assessment appointments with patients given the opportunity to indicate their preferred post-operative pain relief.

Staff assessed pain using verbal and non-verbal cues and with the involvement of relatives and carers if appropriate.

The surgical service had a specialist acute pain team who provided advice and support to patients and staff, for example, when using patient controlled analgesia (PCA).

Staff asked patients about their pain during the two hourly intentional rounding on wards and there were visual aids to assist patients who had difficulties communicating.

Patients told us that pain relieving medication was brought promptly when requested.

**Patient outcomes**

Patient outcomes were monitored in divisional mortality and morbidity meetings and clinical governance meetings.

The trust performed internal outcome audits. These were presented at departmental meetings such as for general surgery, trauma and orthopaedics, anaesthetics or joint meetings.
We reviewed the surgical division audit data and saw that there were a number of ongoing audits in place. The audits that had been completed were shared and presented and those that had recommendations for changes had action plans and implementation dates.

**Relative risk of readmission**

**Trust level**

From July 2016 to June 2017, the overall elective risk of readmission was lower than the England average. The elective risk of readmission for General Surgery was also below the England average.

The Trauma & Orthopaedics and Urology specialties performed worse than the England average. Urology has the most notable poor performance.

The overall non-elective risk of readmission was better than the England average, as was the risk of readmission for the top three non-elective specialties.

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**Elective Admissions – Trust Level**

![Elective Admissions Chart]

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Chart]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

(Source: Hospital Episode Statistics – July 2016 to June 2017)
Hip Fracture Audit

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 5.5%, which was within expected limits. The 2015 figure was 6.1%.

The proportion of patients having surgery on the day of or day after admission was 75.9%, which was worse than the national standard of 85%. The 2015 figure was 76.8%.

The perioperative medical assessment rate was 90.1%, which failed to meet the national standard of 100%. The 2015 figure was 92.9%.

The proportion of patients not developing pressure ulcers was 89.5%, which falls in the bottom 25% of trusts. The 2015 figure was 96.7%.

The length of stay was 18.1 days, which fell in the middle 50% of trusts. The 2015 figure was 18.7 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 73.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 64%.

The risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2015 figure was 5.9%.

The risk-adjusted 2-year post-operative mortality rate was 18% which is within the expected range. The 2015 figure was 12.3%.

The risk-adjusted 30-day unplanned readmission rate was 16% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 39.2% which was within the expected range. The 2015 figure was 35.4%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 6.5% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2015 figure was 0%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 40 days, worse than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 0%. The 2015 figure was 2.4%.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit
In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10.5%. This placed the trust within the middle 50% of all trusts for this measure.

The 90-day post-operative mortality rate was recorded as 'not eligible' for this trust. In 2015 the trust was also recorded to be 'not eligible' for this measure.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 37.4%, which is similar as the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), The Princess Alexandra Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 18 cases.

The Princess Alexandra Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 14 cases.

The Princess Alexandra Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on eight cases.

The Princess Alexandra Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on three cases.

The risk-adjusted 30-day mortality for the Princess Alexandra Hospital was higher than expected based on 64 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients were asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16, performance on groin hernias was about the same as the England average.

For Varicose Veins, performance was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For Knee replacements was about the same as the England average.

(Source: NHS Digital)

Where compliance within an audit was below target, the trust had developed action plans to monitor and address the issues. In addition, healthcare groups worked together to address concerns, for example the surgical health care group was working with the medicine health care group to address the concerns relating to the hip fracture audit.

**Competent staff**

Newly appointed staff had an induction and their competency was assessed before working unsupervised. Competency assessments were varied according to clinical area and need and included PACU competencies, anaesthetic competencies and nursing intravenous therapy and medicines administration. Senior staff reviewed agency and locum staff competencies prior to commencement of work and staff also had inductions before starting work.

Staff confirmed that appraisals were meaningful and identified their learning needs. All staff we spoke with reported receiving annual appraisals and described opportunities for development in their role.

The nursing staff appraisal rate on the Alexandra Day Stay Unit (ADSU) was 97%, Tye Green was 95% and Henry Moore 100%. The rate on Penn ward was 85% and in theatres and the post-operative anaesthetic unit (PACU) was 96%. This had improved considerably since the last inspection.

Staff were provided with development and learning opportunities and several members of staff commented that they were actively encouraged to develop. Junior nursing staff commented that their preceptorship period had been extended to allow them a greater chance of experience.

Staff completed competency assessments pertinent to their role and we saw evidence of improvement of these being monitored with up to date competency charts for skills such as intravenous antibiotic administration on the senior nurse office walls.
Four members of nursing staff we spoke with reported good support with their revalidation process and administration and senior staff confirmed that they received notice when revalidation of staff was due.

Junior doctors we spoke with stated that there were good training opportunities available and there was generally no difficulty accessing courses and experiential learning.

Two student nurses on the surgical wards unit told us that they were enjoying their placements and felt they were receiving good quality teaching.

From July 2017 to August 2017, 75% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:

![Appraisal Completion - Surgery](chart.png)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

We observed staff working together such as physiotherapists, occupational therapists, critical care outreach team (CCOT), nursing and medical staff and saw that there was generally good communication between different staff disciplines. Staff reported strong working relationships among the multi-disciplinary team (MDT).

The surgery service utilised healthcare professionals such as pharmacists, occupational therapists, physiotherapists and dieticians to work together with the nursing and medical teams to assess, plan and deliver care and treatment to patients.

Staff used the multidisciplinary care plan booklet which ensured that all staff had access to the most up to date patient information used by other members of the MDT.

Staff discussed discharge needs with patients, families and carers at pre admission clinics and liaised with other services and organisations where appropriate.
We observed a daily inpatient board round and patient management meeting where all members contributed to planning patient care.

We reviewed a range of surgical MDT meeting minutes and found them to be comprehensive with evidence of interagency working and updated treatment plans.

Seven-day services

Acute and emergency surgical services were available seven days a week. Medical and anaesthetist cover was provided outside of normal working hours on a rota basis. Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards during out of hours periods. There was also on-call cover provided by consultant surgeons who could be contacted by telephone.

At the time of inspection the trust was in the process of reintroducing the designated emergency surgical assessment unit. This opened in a much reduced capacity on the last day of inspection. The plan was for the unit to be open to assess patients who may require emergency surgery between 8am and 8pm daily with a doctor available on the unit.

The Alexandra day surgery unit (ADSU) was open from 7.45am till 8.30pm Monday to Friday. Patients who were not ready to go home at 8pm were generally returned to the main post anaesthetic recovery area (PACU). There was a consultation being held regarding the opening of the day unit at weekends and longer into the evening to use the facilities more effectively.

Physiotherapy services were available at weekends to care for patients assessed as a priority.

Health promotion

Health promotion was encouraged with patients being provided information on smoking cessation, healthy heart and diet at pre-assessment clinics and in the ADSU.

There were a range of leaflets available to support patients’ recoveries.

Patients were encouraged and supported to mobilise as soon as possible after surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Planned surgical procedures were generally discussed during outpatient clinic consultations and informed consent obtained by the medical staff however nursing staff, told us consent for surgery was occasionally obtained on the day of the procedure. This does not comply with accepted best practice. The Royal College of Surgeons recommends ‘the patient has sufficient time and information to make an informed decision’.

Consent forms in patient notes recorded information such as; the procedure, levels of discomfort, post-operative pain relief and discharge plan.

Patient’s we spoke with informed us that they felt fully informed and were happy with the consent process.

Staff described how they would deal with patient attending the (ADSU) without capacity. This included escalation to medical staff and involvement of family members making ‘best interest decisions’.
We observed staff asking for consent when performing examinations and performing personal care.

Training on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) was incorporated in mandatory safeguarding training. Staff described the process of assessing capacity and felt confident in doing so. We reviewed one set of notes which showed the appropriate assessment had been completed. We reviewed one DOLS application and saw that the appropriate procedure was followed.

Is the service caring?

Compassionate care

We spoke to six patients and two relatives. They described care as being exemplary with excellent care from all staff. This included nurses, health care assistants, (including bank and agency staff), student nurses, doctors, therapists, porters and administrative staff.

During our inspection patients we spoke to were very positive regarding the care they had received describing the staff as; “amazing” and “could not do enough for me”, “they work really hard and are always smiling”, the staff are fantastic and could not be better. They keep you informed all the time and in words I can understand” and “they always have time even though you can see they are busy”.

We observed staff interacting with patients both in person and by telephone, treating them with kindness and respect.

Staff were aware of patients’ care needs and communicated in an appropriate friendly and professional manner.

We also observed very positive interactions between nursing staff on Penn ward especially who were willing to support and assist each other with tasks despite high levels of activity in the department.

The ADSU staff liaised with local charities and for the month of December every child who passed through the ADSU received a gift.

Friends and family test response rate at The Princess Alexandra Hospital NHS Trust, by site.

The Friends and Family Test response rate for surgery at The Princess Alexandra Hospital NHS Trust was 57%, which was better than the England average from September 2016 to August 2017.

A breakdown of response rate by site can be viewed below.
The graph includes data from Saunders ward which is no longer a surgical ward. *(Source: NHS England Friends and Family Test)*

![Graph showing percentages](image)

The most recent Friends and Family Test results for the surgical wards was from October 2017 and showed that the average rating was 99%, which was better than the England average of 96%. This had improved since our last inspection.

**Emotional support**

Patients had access to a trust wide chaplaincy service. This was advertised on notice boards within the surgical wards and ADSU.

There were faith champions available on the wards to provide emotional support and spiritual care.

Staff had access to guidance on arranging spiritual support for relatives and patients irrespective of faith denomination.

A mental health liaison team of professionals were available and we were told they responded in a timely manner when requested.

We observed staff using a gentle touch on the hand to reassure nervous patients and taking time to listen to patient’s fears.

There were specialist nurses available within specific specialities who provided additional emotional support both prior to admission and after discharge.

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

All the patients we spoke with said they had felt involved in their care planning and decision-making. They told us they received information about care and treatment in a manner they understood.

The surgical wards displayed a wide range of information for patients and their families on large notice boards and leaflet racks at the entrances and around the ward.
Ward staff encouraged families to complete passport documentation, for patients living with dementia. The documentation included the patient’s preferences, for example food likes and dislikes.

One family member of a patient who had been admitted for a second time told us that they had been kept informed throughout their relatives care and described the staff as amazing.

On Penn ward arrangements had been made to accommodate a relative staying with a patient in a side room in a recliner chair to ensure that the patient whose first language was not English did not feel distressed.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

There was pay parking on site for relatives and carers visiting patients but this did become difficult during outpatient clinic periods and two relatives told us it was not uncommon to drive around for up to 20 minutes looking for a parking space.

Visiting on the wards was generally between 3pm to 4.30pm and 6.30pm to 8pm with a protected rest and meal period for patients between 4.30 and 6.30pm.

The theatre suite provided eight theatres in the main suite, four in the Alexandra Day Surgery Unit (ADSU) and one obstetric theatre located in the maternity delivery suite.

The elective theatres were divided into; two orthopaedic, one urology, one gynaecology and two general theatres. One of the remaining theatres was available for emergency general surgery and staffed 24 hours, seven days per week. This meant that operations could be performed for patients that required emergency surgery at any time of the day or night.

The remaining trauma theatre was staffed Sunday to Friday but the trust had recently trialled a Saturday trauma theatre list and found this worked well so were looking at including this permanently.

The ADSU had recovery bed spaces for 17 patients divided into male and female areas, there was also a 6 bedded paediatric area staffed by three nurses with paediatric training.

A range of elective surgical procedures were available, some of which were done as day case procedures in the ADSU (meaning that patients could be discharged on the same day as the procedure).

**Average length of stay**

**Trust Level – elective patients**

From August 2016 to July 2017, the average length of stay across all elective surgeries was better than the England average.
Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Trust Level – non-elective patients
From August 2016 to July 2017, the average length of stay across all non-elective surgeries was slightly worse than the England average.

Non-Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Meeting people’s individual needs
The trust provided access to care and treatment at a time to suit patients where possible. A relative of a patient on the ADSU commented that they had used the service recently as had other members of the family. They praised the service for the flexibility around dates and times for treatment and the efficient process for pre assessment and admission.

An enhanced recovery service was available for some surgical procedures led by a specialist nurse with consultant anaesthetist and surgeon support. The service offered personalised care and support and practical advice prior to, during admission, and after surgery for patients undergoing, primarily gynaecology and bowel resection surgery.

The surgery service had access to an intermediate care team who assisted in discharge planning and arrangements for patients.

The trust has adopted the perioperative guidelines for diabetes which recommends that patients with diabetes should be first on the theatre schedule for their procedure.

Patients with dementia or learning disabilities were prioritised to the beginning of lists if possible to help minimise any distress. The trust used the ‘Forget Me Not’ symbol above the patient’s bed to identify patients with dementia additional needs and the ‘This Is Me’ Tool to support those patients.
Relatives and carers were accommodated on the wards and in the ADSU to support patients with additional needs such as language, dementia or learning disabilities.

Staff provided patients with discharge information for wound care and who to contact if they had concerns post-operatively.

Staff had access to interpreting services for patients whose first language was not English. Face to face translators could be booked in advance at preoperative assessment clinic and interpreters could accompany patients to theatre or on ward visits to support therapy assessments.

There was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The leaflets were only in English but could be ordered in other languages or alternative formats if required.

On the surgical wards we saw staff provided comfort items such as dolls for patients with dementia to help alleviate distress.

Staff on Tye Green ward had a charity/tombola table, which they provided items for raffle. They used the proceeds to decorate and furnish a ‘quiet room’ on the ward for relatives and carers. This was also used by nursing and medical staff for delivering bad news or comforting family members. The room was sympathetically decorated and supplied with tea and coffee making facilities and comfortable seating.

On Tye Green ward staff had developed a ‘consultant wall of fame’ where they were in the process of obtaining photographs of all the surgical consultants so that patients and visitors could identify them.

Following complaints regarding hot drinks being cool by the time patients received them a new hot drinks system had been introduced.

The service had access to an intermediate care team to assist in the discharge of patients and planning ongoing recovery.

Following concerns regarding noise at night and the time taken to answer call bells the surgery health care group undertook monthly audits of call bell, light and sound spot checks. Patients completed questionnaires and the November 2017 results showed 69% were satisfied with the level of noise at night, 94% felt that lights were turned off in a timely manner and 86% were satisfied with the call bell response time. We observed that call bells were answered promptly on Tye Green ward however call bells took longer to be answered on Penn ward and there was one instance where a bell went unanswered for nine minutes. We did not hear any call bells on Henry Moore ward, the PACU or the ASU.

Access and flow

Patients attending for surgery were admitted via the admissions area on Netteswell ward. Once initial observations, clinical reviews and paperwork had been completed and they were changed into gowns ready for theatre, and they then walked (if mobile) round to the theatre waiting area before being taken into the anaesthetic room.

Patient belongings were packed into bags and taken round to the theatre waiting area on a trolley. We were concerned that there was no-one directly responsible for patient belongings during this time. We raised this with senior staff who reported that there had been only one episode of a bag going missing between PACU and transfer to a ward, and that it had been reported and was being investigated. There were no plans to review the process at the time of our inspection.
Patients who were listed for joint replacement surgery were admitted to Henry Moore ward and went to theatre direct from the ward to reduce contact with possible infection. Once surgery was complete, they were moved to the post anaesthetic care unit (PACU) until ready to move to the ward if an inpatient.

Patients admitted via the emergency department were reviewed on the wards following admission. The surgeon and anaesthetist reviewed patients admitted via the elective service on the day of surgery to ensure they were medically fit for the surgery.

On ADSU patients were admitted direct to the unit and usually had surgery in the ADSU theatres or in main theatres before recovering on the unit prior to discharge.

In some instances, patients were admitted via Nettleswell ward, had surgery in the main theatres and then transferred to the ADSU until they were ready for discharge. The distance between main theatres and the ADSU was considerable and involved passing through very busy areas including a corridor with waiting area seating next to the onsite café, and a brief trip outside. Staff commented that patients who were not ready to be discharged when the ADSU closed at 8.30pm were transferred back to the PACU until they were ready to be discharged home directly from there. At times discharge could be as late as 11pm at night.

We observed this being discussed for 12 patients on the ADSU during our inspection. This meant that some patients were moved twice postoperatively at a time when they may be feeling unwell. Figures supplied by the trust following the inspection showed 49 patients were discharged between 10pm and 7am during the period June to November 2017. There was no standard operating procedure for patients transferring back and forth to the ADSU at the time of inspection however; a standard operating procedure was introduced following our inspection. This made it a requirement that staff informed all patients prior to surgery of the likelihood of being moved.

The PACU staff were concerned that they were not staffed for caring and discharging extra patients late at night as they had reduced staffing for emergencies only at those times. They reported that they had raised concerns with senior staff although not completed incident report forms. Senior staff we spoke with said they were aware of the issue and that there was a consultation in progress about the ADSU remaining open longer to accommodate these patients.

The practice of regularly holding patients in PACU overnight or admitting critical care patients direct to PACU, which had been common at the last inspection, had significantly improved with no patients held on PACU under these circumstances during the period August to December 2018.

The ADSU theatres were also being used to perform caesarean sections and gynaecological procedures such as terminations of pregnancy (as the unit was near the maternity department) and we saw pregnant women and their partners in the waiting areas whilst on inspection. The senior nurse confirmed they would ensure that these patients waited and recovered in separate areas. A second obstetric theatre was in the planning stage, which will alleviate this in future.

At our previous inspection, we raised concerns regarding the number of patients transferred between wards moves that occurred at night (between 10pm and 8am). The trust supplied information that there were 734 patients who had been moved at night between August 2016 and July 2017. Information supplied following this inspection showed here had been 13 moves that had occurred at night between June 2017 and December 2017. This was a significant improvement from our previous inspection.

Referral to treatment time (RTT) is the part of the NHS constitution and means that patients have the right to start treatment within 18 weeks of being referred.
Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. There was some fluctuation in the trust’s performance, with a gradual trend of improvement from September 2016 through to March 2017, bringing the trust just below the England average. From May 2017 onwards, that trend was reversed with a minor decline which endured to the end of the reporting period.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for the specialties that were below the England average is in the table below.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0%</td>
<td>84%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>70%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73%</td>
<td>74%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.0</td>
<td>82%</td>
</tr>
<tr>
<td>Urology</td>
<td>51%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed an upward trend after a period of reduced performance, and was generally lower than the England average. Despite a decline in Q4 2015/16, the trust’s performance shows strong improvement through Q1 2016/17, reaching a 0% rate by Q2 2016/17.

Between September and November 2017, there were 148 surgeries cancelled due to lack of bed capacity. The trust rescheduled all of the surgeries within 28 days. Senior staff confirmed that lack of beds was one of the biggest challenges of the surgical service. At the time of inspection there were nine medical patients on Tye Green ward and nine on Penn ward which meant those beds were not available for surgical patients.

Percentage of patients whose operation was cancelled and were not treated within 28 days - The Princess Alexandra Hospital NHS Trust
Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. There was a notable trend of decline from Q2 2016/17 through to Q4 2016/17. From here there is a minor improvement to the end of the reporting period. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

From August 2016 to July 2017, there were 52 complaints about Surgical Care. The trust took an average of 64 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with in line with the national policy of 180 days. The eye unit holds the greatest proportion of complaints at 13, of these the crux of the complaints is either operations gone awry or lack of capacity.

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Patients that we spoke to knew how to make a complaint and felt confident to do so although none had found it necessary.

Local ward managers were responsible for investigating complaints in their areas and had undertaken training to do so.
The trust treated concerns and complaints seriously, investigated them and learned lessons from the results. All complaints were recorded on the trust-wide system and there was oversight in the regular performance meetings.

Information on how to complain was clearly displayed on notice boards on the wards and ADSU. The information whiteboards at the entrance to each ward displayed the number of complaints each month. Feedback and learning from complaints was shared at face to face and ward meetings and displayed in staffrooms.

The trust used a ‘You Said, We Did’ approach to generalised complaints. For surgery the most prevalent was:

- **You Said**: You had concerns regarding post-operative care and fully understanding consent and the procedure.
- **We Did**: We worked together to review the patient information leaflet relating to consenting to a procedure and made adaptations to the information to make the process suitable for vulnerable groups.
- **Together We Achieved**: A commitment from senior clinical and managerial staff to continue to work with patient groups to develop practice and information.

## Is the service well-led?

### Leadership

The surgical health care group leadership team consisted of a divisional clinical director, associate director of nursing and a deputy director of operations.

The leadership team told us that previous leadership had been disjointed with transient staff and a lack of consistency, but this had improved since the last inspection and they now had a full complement of leadership staff. Staff spoke of a consistent structure that is making a difference.

There were clearly defined and visible leadership roles across the surgical health care group. The leads were supported by teams of directorate and operational managers, matrons, ward and theatre managers.

Band seven managers led wards and departments or team leaders supported by band six staff. The matron’s bases had recently been relocated onto Tye Green and Penn ward and staff on Tye Green felt this was of significant benefit as they valued the closer support.

Staff told us and we saw during the inspection, that matrons and the head of nursing were very visible on the wards. Matrons attended trust wide bed state and staff briefings twice daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients.

Medical and nursing staff understood management reporting structures and told us they were well supported by their managers.

### Vision and strategy

Staff knew of the trust vision ‘Your future, our hospital’ and what it wanted to achieve, however; there was no specific vision or strategy for the surgical division in place. Senior staff commented...
that it had not been rolled out yet and was ‘a work in in progress’, at present they used the trust vision.

The trust vision was supplemented by five-year plans for all of the departments and specialties based on the local PAH five P framework of:

- Our Patients
- Our People
- Our Performance
- Our Places and
- Our Pounds

We saw posters on the surgical wards and areas with the five Ps and all staff we spoke with knew of the five Ps framework.

**Culture**

Staff reported that generally there had been improvements in the culture across the surgical division since the last inspection and with the new chief executive team.

Most managers across the surgical health care group promoted a positive culture that supported and valued staff. We did witness an episode where this did not happen and several members of staff admitted that there problems with this particular person. We were reassured that the individual was being managed appropriately.

The trust senior nurse was known throughout the division and personal notes of thanks for hard work to individuals and ward teams were noted on the ward noticeboards. Staff commented that this was not unusual and they were very proud to receive them.

It was evident that managers from the leadership team down to ward managers were very proud of their teams in the way in which they spoke of them and celebrated their successes.

There was improvement since the last inspection in the positive culture of incident reporting that encouraged learning and improvements in care.

Staff morale was variable dependant on workplace, workload and acuity of patients however; all staff described a good team working culture.

Many of the staff we spoke to had been employed for several years at the trust and demonstrated strong commitment to the hospital.

Senior nursing and medical staff were visible throughout the surgical areas. They were actively involved in the daily management and support of the service. The senior nursing staff had moved offices to join the ward managers since the last inspection and this was seen as a positive move by staff.

Junior grade doctors told us they felt reasonably well supported but sometimes there was difficulty accessing middle grade/senior colleagues if in theatres. The General Medical Council (GMC) National Training Survey results for 2017 showed that in 10 out of 17 questions the general surgery respondents reported significantly lower than the national averages. The Urology respondents reported four out of 17 below national averages whilst the trauma and orthopaedics and anaesthetic respondents were similar to national averages. The questions covered a range of subjects from general satisfaction to clinical supervision and workload. The themes for poor scores
related to handover and teamwork with the most significant low score in general surgery being workload.

**Governance**

Weekly divisional governance meetings were held that linked in with trust-wide clinical effectiveness committee meetings. The surgical executive team had also introduced a ‘theatre users group to address concerns specifically around the operating theatre usage. We reviewed the minutes of the meeting held on 21 November 2017 and saw that they addressed concerns and had action plans with expected completion dates to be reviewed each meeting.

There was a general improvement in the governance and oversight of quality measurements since the last inspection with senior staff working together to improve patient experience and outcomes.

Monthly divisional board meetings took place and were attended by senior staff including medical and nursing staff and clinical audit and governance leads. Discussions took place regarding issues such as complaints, risks, serious incidents and lessons learnt.

Agenda items from divisional clinical governance meetings were discussed at monthly quality and safety committee meetings for governance assurance and approval processes.

There was a lack of management oversight and governance to ensure that medical staff had regular appraisal and training.

**Management of risk, issues and performance**

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Ward managers contributed to monthly risk register and performance reports which were escalated to the divisional, and subsequent trust board if appropriate, and this was seen in meeting minutes.

The surgery division had a risk register containing 40 risks and there was also a corporate risk register. Items on the surgery division risk register were discussed in governance meetings and updated as needed although we noted that not all risks had review dates or action plans. The oldest risk dated to 2014 and related to the lack of specialist nurse roles. Staff shortages across the division, finance and environmental factors were the most common risks.

Senior staff knew what was on their risk register but it was not clear if this was shared with junior staff.

There were monthly risk committee meetings and the surgery division split the risk register by ward/service. Access was made available to matrons, ward managers, service leads and senior staff to allow individuals to add or edit their own risks and enable better oversight of risk as a whole.

The surgical division had processes for managing performance. Senior nursing staff reviewed performance monthly via the key performance quality indicators and this was disseminated to all staff and displayed on the ward information boards.
Information management

Staff used handheld electronic tablets for recording clinical observations on the wards, these were password protected, and ceased working if they were removed from the building. This protected patient confidential data.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

All electronic policies we reviewed were within date however; we noted that some paper copies of policies were held which were out of date such as on Penn ward. This meant that staff could potentially refer to out of date or misleading information.

Engagement

Staff were positive about the open lines of communication with the executive board and several members of staff had had attended the weekly Tuesday morning executive briefing, which was open to all staff.

The chief executive officer (CEO) sent out a weekly email update, which all staff had access to and had a separate email address for any staff member to email them with any query or concern.

The surgical division recently held a ‘mini Oscars ceremony’ to celebrate individual achievements. Nominees were presented with certificates in front of colleagues and staff who had received awards said they felt very proud.

Trust wide there was a staff recognition ‘Amazing People Award’ which several of the surgical staff had been nominated for by colleagues.

Staff spoke about the recent September 2017 ‘event in a tent’. This was a marquee set up in the hospital grounds organised to launch the ‘Your future, our hospital’ improvement plan. The event was open to staff, local community and stakeholders/partners.

Senior staff spoke of ongoing collaborative working with partner organisations in a ‘Hub and Spoke model’ for vascular surgery.

There was limited engagement with service users with no active participation in any improvement measures. This was a focus for the division going forward.

Learning, continuous improvement and innovation

There was a positive drive for learning, and access to courses such as those for leadership was available.

Staff commented that they were encouraged to develop and if they identified courses that were suitable, senior staff strived to arrange funding.

Senior staff did take time to work together to resolve problems but this appeared to be a relatively new development and was not deeply embedded.

Morbidity and mortality meetings were held to review complicated cases. There was some evidence in meeting minutes that discussion took place, however the reviews that the trust supplied post inspection did not provide assurance that they were used to learn and make improvements.
Critical care

Facts and data about this service
The critical care department comprises of anaesthetics, intensive care and high dependency critical care outreach team (CCOT) and resuscitation services.

The critical care unit can accommodate both intensive (level 3) plus high dependency (level 2) patients. The critical care unit is also able to respond to the dependency needs of their patients flexibly to ensure an appropriate level of care is delivered at all times.

(Source: Trust Provider Information Request)

The trust has 15 critical care beds. A breakdown of these beds by type is below.


![Breakdown of critical care beds](chart.png)

(Source: NHS England)

Princess Alexandra Hospital has two critical care wards, which form the critical care unit (CRCU): the intensive treatment unit (ITU) and high dependency unit (HDU). As of July 2017, there were 54.14 nursing whole time equivalents (WTE) and six other clinical WTE.

(Source: Trust Provider Information Request)

During our inspection, we visited ITU and HDU. We spoke with 18 staff (14 nursing and four medical), three patients, three family or carers and reviewed six medical care records.

Is the service safe?

Mandatory training
The trust delivered mandatory training as a combination of classroom sessions and on line learning. Senior nursing staff updated and displayed mandatory training compliance rates monthly in the seminar room. This provided a visual reminder for staff to attend any outstanding training.

The trust set a target of 95% for completion of mandatory training.
A breakdown of compliance for mandatory courses up to July 2017, for nursing staff in critical care, is shown below:

**Mandatory training completion by module critical care Princess Alexandra Hospital NHS trust (Nursing and Midwifery Registered)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Level 2</td>
<td>33</td>
<td>37</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>47</td>
<td>55</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>43</td>
<td>55</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>43</td>
<td>56</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery registered staff within critical care did not meet the 95% target for any of the five modules they were required to complete. The lowest completion was for information governance with 77%.

The most recent overall compliance for mandatory training for nursing staff on the critical care unit (CRCU) was 98% (60 out of 61 nursing staff) and this exceeded the trust target of 95% at November 2017.

The trust told us they had implemented a new, trust wide, immediate life support (ILS) course. The ILS course is mandatory for those nurses working within critical care. At the time of inspection, compliance was 49%, however, the trust had only started delivering the course in January 2017.

The trust told us they had introduced several additional course dates to ensure capacity met demand and delivered the course on a weekend to improve attendance from resource challenged departments.

**Mandatory training completion by module critical care Princess Alexandra Hospital NHS trust (Medical staff)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Level 2</td>
<td>10</td>
<td>16</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>14</td>
<td>16</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling Level 2</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire</td>
<td>11</td>
<td>16</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>13</td>
<td>16</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff within critical care did not meet the 95%90% target for any of the five modules they were required to complete. The lowest completion was for moving and handling level 2 with 60%.

Information provided by the trust stated “All registered bank and agency staff receive ward orientation and records are kept at ward level. Relevant agency staff are assessed for Intravenous drug administration competence prior to being able to carry out administration”

**Safeguarding**

The trust set a target of 95% for completion of safeguarding adult training and 90% for safeguarding level 2 training.

A breakdown of compliance for safeguarding courses up to July 2017 for nursing/midwifery staff is shown below:

**Safeguarding training completion by module critical care Princess Alexandra Hospital NHS trust (Nursing and Midwifery Registered)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children level 2</td>
<td>54</td>
<td>55</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults level 2</td>
<td>50</td>
<td>55</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery registered staff within critical care did not meet the 95% target for one of the two safeguarding modules they were required to complete.

At the time of our inspection, nursing staff were exceeding the trusts 95% compliance target for safeguarding children and adults training. We saw data displayed in the CRCU to confirm this. The CRCU had not cared for any children in the 12 months prior to our inspection.

**Safeguarding training completion by module critical care Princess Alexandra Hospital NHS trust (Medical)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children level 2</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults level 2</td>
<td>12</td>
<td>16</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff within critical care did not meet the 95% target for both the safeguarding modules they were required to complete.

Nursing staff we spoke with understood their responsibilities to raise safeguarding concerns and gave an example of when they had done this for an elderly patient who arrived on the unit from home and showed signs of neglect.
Posters displayed in the critical care unit (CRCU) detailed the safeguarding process, who to contact and what steps to take in the event of a safeguarding concern.

The CRCU had a safeguarding champion as a direct point of contact between the unit and the hospital safeguarding team. The role of the safeguarding champion was to support CRCU staff with any safeguarding concerns.

Nursing staff described the trust wide Daisy project which was a trust wide initiative about recognising and responding to people at risk of domestic violence.

Cleanliness, infection control and hygiene
All ward areas we visited, including the stock room, cleaners store room and the bathroom were visibly clean and tidy.

Nursing staff washed their hands before and after delivering care to patients and used hand sanitiser in line with National Institute for Health and Care Excellence (NICE) quality statement (QS) 61 statement 3; patients received healthcare from healthcare workers who decontaminate their hands before and after every episode of patient contact or care.

The trust used automatic sanitising gel dispensing door handles on the door to the ITU. This ensured all visitors to the unit sanitised their hands on entry.

The trust displayed posters throughout the CRCU reminding visitors to the unit to wash their hands and the importance of “Five moments of hand hygiene.” We observed nursing and domestic staff challenge two medics who were leaving the unit without washing their hands.

The trust monitored hand hygiene compliance monthly. For the three months, September, October, November 2017 nursing staff were 100% compliant on the CRCU.

Nursing and medical staff arms were bare below the elbow in line with department of health (DH) guidelines and used personal protective equipment (PPE) such as disposable aprons and gloves when providing personal care.

The trust recorded staff compliance with infection control standards, during September, October, and November 2017 compliance was 100% this was above the trust target of 95%.

Nursing staff delivered care in line with NICE QS61 statement 4; people who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer required.

Nursing staff recorded care of the catheter in the CRCU specific admission and discharge booklet and signed and dated entries. Nursing staff used the trusts invasive lines care bundle to reduce the risk of infection for those patients with invasive lines and catheters. The trust reported no catheter induced urinary tract infections during the period December 2016 to November 2017.

Nursing staff delivered care in line with NICE QS61 statement 5; people who need a vascular access device have their risk of infection minimised by the completion of specific procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it is no longer needed. Nursing staff recorded care of the device in the CRCU specific admission, discharge booklet, signed, and dated entries. We reviewed the medical care records for one patient who had a central line in place. Nursing staff had checked the line daily, signed, and dated the record.
The CRCU reported no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), no cases of Clostridium difficile (C. difficile) and no cases of vancomycin-resistant enterococci (VRE) for the month of November 2017.

The trust used disposable curtains around patient bed spaces. Nursing staff changed curtains if they were soiled or had been used in the bed space of an infectious patient. Nursing staff routinely replaced curtains on a six monthly basis. Nursing staff recorded the replacement date on the curtains and all the curtains we reviewed were visibly clean and within date for disposal.

Nursing staff used cream coloured curtains around the bed space of infectious patients who were being nursed in the ward area. This provided an obvious visual sign to visiting medics and nursing staff to take extra infection prevention precautions.

Nursing staff used “I am clean” stickers on equipment once they had cleaned it. This ensured there was no cross contamination between patients using the same equipment. All equipment was in date at the time of our inspection.

In the high dependency unit (HDU) we observed nursing staff used plastic reusable bowls when washing patients but there was no clear plan for sterilising the bowls between uses. We were concerned this was not good practice due to the bowls being used for all aspects of personal care and the possible risks of cross infection from wound sites or intimate areas. We raised our concerns regarding this practice. We were informed that another area in the trust used disposable bowls. Each bowl was only ever used on one patient. The ward manager said they would explore this as an option with the infection prevention and control team to minimise the risk of infection from reusing wash bowls.

Domestic staff flushed water taps daily to prevent bacterial build up. Records of flushing were complete for November 2017.

In the intensive treatment unit (ITU), nursing and medical staff used non-touch taps and automatic hand towel dispensers to reduce the risk of infection during hand washing.

A team of four domestic ward orderlies cleaned the CRCU. Two staff worked on the unit Monday to Friday 7.30am to 1.30pm and two staff from 1.30pm to 7pm. Tasks included emptying waste bins, cleaning toilets and floors, ensuring the availability of personal protective equipment and hand sanitiser gel among other tasks. We reviewed the task list for one week in October and saw domestic staff had completed all relevant tasks and signed and dated the record.

Staff on the CRCU carried out waste segregation using different coloured bags for clinical waste and domestic waste. Nursing staff labelled sharps bins appropriately and did not overfill them.

Environment and equipment

The critical care unit (CRCU) was secure. Access to the unit for visitors was via a buzzer and intercom system.

The CRCU provided level three care for up to seven patients in the intensive treatment unit (ITU) with level two care in high dependency unit (HDU) for up to five patients. However, the trust only had funding for nine beds and therefore three beds in the ITU were routinely not in use.

Critical care nursing staff had access to a “pop up” isolation room within the unit. The room had the option of positive or negative airflow, which meant there was good infection prevention control for patients in isolation due to reduce transfer of airborne infectious agents.
Staff on the CRCU had recently obtained a hoist with built in weighing facility. This meant nursing staff could weigh patients directly and more accurately to monitor their nutrition and for correct drug doses. Previously nursing staff weighed patients indirectly by weighing them in their beds and then subtracted the weight of the bed. In the patient medical records we reviewed nursing staff had recorded patient weights accurately.

We reviewed nine pieces of electrical equipment including portable ventilators, blood pressure monitors, electrocardiogram (ECG) machines and an ultrasound scanner on the CRCU. Engineering staff had completed portable electrical appliance testing (PAT) had on all pieces of the equipment within the last 12 months.

Since our previous inspection, nursing staff had introduced a CRCU equipment inventory record. Nursing staff recorded the equipment, the date and who had taken it if another ward wanted to borrow a piece of equipment. This meant the CRCU nursing staff always knew where equipment was.

Nursing staff opened and checked the contents of the resuscitation trolley in ITU and HDU on a weekly basis before sealing it with a numbered tag. Nursing staff checked the seal was not broken on a daily basis. We broke the seal on the trolley in the ITU, nursing staff kept the trolley tidy and well organised and records showed staff had completed daily equipment checks in November 2017 with no gaps. This was an improvement since our last inspection where we found nursing staff were not consistently checking the trolley.

Nursing staff opened and checked the contents of the difficult airway trolley on a weekly basis before sealing it with a numbered tag. Nursing staff checked the seal was not broken on a daily basis. Nursing staff kept the trolley tidy and well organised and records showed staff completed daily checks in November 2017. This was an improvement since our last inspection where we found nursing staff had not checked the contents of the trolley for over five months and the trolley was disorganised and untidy. We identified one item, which was not in sterile packaging. We raised this with the nursing staff and the item was replaced.

Nursing and domestic staff stored sterilising tablets in locked cupboards within the cleaning storeroom.

Nursing and medical staff observed the trust wide waste disposal policy and we observed good waste segregation throughout the CRCU.

Nursing staff kept the consumable storeroom well stocked, tidy and stored items appropriately. We selected five items at random including central line kits and noted they were all within use by date and in sterile packaging.

We were concerned about the lock on the inside of the bathroom door as potentially patients could become trapped inside. We raised our concerns with senior nursing staff who assured us that the lock could be opened from the outside in case of an emergency.

The HDU had two hand basins, both with manual taps, at one end of the unit. Nursing and medical staff had to pass through bed spaces of the other patients in the unit in order to wash their hands. We were concerned about the infection prevention and control (IPC) implications. We raised this with nursing staff who assured us the IPC team were aware of the situation.

The HDU was very small and there was a shortage of space around beds. This was not compliant with the department of health (DH) health building note (HBN) 04-02 6.10 A 2.5 m-wide unobstructed circulation space should be provided at the foot of each bed space. It is imperative to maintain the required bed separation for infection control reasons and to aid positioning of
Assessing and responding to patient risk

Nursing staff showed us the emergency buzzer in the HDU which they could press in the event of a cardiac arrest. ITU staff were aware of the buzzer but had not needed to use it. Data supplied by the trust showed six out of 12 (50%) critical care (CRCU) medical staff had completed adult basic life support.

CRCU nursing staff completed CRCU specific admission and discharge booklets for each patient. This was an improvement since our last inspection where we found staff had not completed admission and discharge booklets for three out of five patients. The booklet included risk assessments for falls, bedrails, nutritional screening, pressure ulcers (PU), mouth care as well as pain scoring tools, care plans and records of comfort rounding. Nursing staff completed all the booklets we reviewed appropriately, clearly and signed and dated entries.

Nursing staff carried out comprehensive risk assessments for patient pressure ulcers, falls, nutrition, and delirium on all patients admitted to the CRCU. Nursing staff completed risk assessments appropriately, signed, and dated them in all the patient care records we reviewed. This was an improvement since our last inspection where we found staff had not completed risk assessments for pressure ulcers (Waterlow score) in 40% of patient records reviewed.

Nursing staff carried out venous thromboembolism (VTE) risk assessments in line with national institute for health and care excellence (NICE). Specifically quality statement (QS)3 that all patients, on admission, received an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool and NICE QS3 Statement 4: Patients were reassessed within 24 hours of admission.

Nursing staff requested pressure-relieving mattresses for those patients deemed at risk of pressure ulcers.

The CRCU had an “ANTS” team – agents of nutrition and tissue viability. This was a team of CRCU nursing staff trained in nutrition and pressure ulcer prevention who were available to offer support to the nursing staff around nutrition and PUs. At the time of inspection the CRCU reported 270 days without an avoidable pressure ulcer.

Nursing staff continually assessed patient health using the national early warning system (NWES) method. Nursing staff had calculated NEWS scores correctly in the six patient care records we reviewed.

Audit data supplied by the trust for the three months June to August 2017 showed 100% compliance with vital signs standards (NEWS) against a trust target of 95%.

The trust had a critical care outreach team (CCOT). Nursing staff escalated any patient NWES score greater than five to the CCOT team who immediately reviewed the patient. The CCOT team also attended any patients with pancreatitis, cardiac arrest or who nursing staff were concerned about. The CCOT team recorded their input in the patient medical records, signed and dated them.

The CCOT reviewed all patients discharged from ITU and HDU at least once daily until they were clinically stable. The CCOT also took referrals of acutely deteriorating ward patients following triggering of the National Early Warning Score (NEWS) tool in other hospital areas. CCOT
attended all cardiac arrests and undertook root cause analysis (RCA) on each one. CCOT nurses accompanied any patients who were being transferred to tertiary centres.

Nursing staff treated patients with sepsis in line with the “Sepsis 6” care bundle. Two patient medical care records we reviewed evidenced the sepsis 6 care bundle in use.

Nursing staff had access to trust wide mental health services, 24 hours per day and seven days per week, if they had concerns about a patient. During our inspection, a mental health nurse visited a patient transferring to a ward in order to meet them and begin planning their ongoing care.

**Nurse staffing**

The trust reported their staffing numbers below for the period April 2017 and July 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>62.48</td>
<td>54.14</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From August 2016 to July 2017, the trust reported a vacancy rate of 12% in critical care. This equated to rates of vacancies on CRCU: 20% and Critical care outreach team: over established by 38%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From August 2016 to July 2017, the trust reported a turnover rate of 16% in critical care, which is higher than the trust target of 11%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From August 2016 to July 2017, the trust reported a sickness rate of 2.7% in critical care: CRCU: 3.2% and Critical care outreach team: over established by 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
The trust reported the total number of shifts over the 12 month period August 2016 to July 2017 as 1258.

From August 2016 to July 2017, the trust reported for the critical care outreach team there was a bank use for 59 shifts, of which 93% were covered by bank staff, two shifts were covered by agency staff and a further two were unfilled.

In ITU A total of 1,258 shifts were covered over the 12 month period of which 58% were covered by bank staff and 166 shifts were covered by agency staff leaving a total of 368 shifts unfilled (around 30 a month).

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Nursing staff used the Shelford Safer Nursing Care Acuity Tool to plan staffing requirements according to patient need. At the time of our inspection, the CRCU was understaffed in trained band 5 registered nurses (RN) by 21% this was a shortfall of 12 WTE. However, this was an improvement since our last inspection where the vacancy rate was 35%. The trust had a rolling recruitment programme for nurses.

The CRCU was also understaffed by health care assistants (HCAs) by 42.8%, a shortfall of four WTE staff.

Senior CRCU nursing staff used social media to advertise any unfilled shifts to the CRCU nursing staff. Nursing staff volunteered for the shifts and this meant the CRCU did not need to use any agency staff. Staff told us this worked well as they did not feel under pressure to accept additional shifts.

Nursing staff used a “temporary staff checklist” to ensure any staff who did not routinely work on the ward knew the safety systems and processes such as handwashing, uniform, and record keeping. Forms were signed by the staff member and countersigned by the senior nurse on the ward.

During our inspection, the actual nurse staffing numbers matched the planned staffing requirements. Nursing staff picked up additional shifts to minimise the use of bank and agency nurses. Nursing staff rotated every two months between the HDU and ITU to maintain their clinical skills.

According to the Faculty of Intensive Care Medicine (FICM) national standards, Level 3 patients require one registered nurse (RN) to one patient and one RN to two patients for Level 2 patients. The trust told us this was not audited but nursing staff assessed patient acuity and nurse staffing levels on a day by day basis.

According to the FICM national standards, there should be an additional supernumerary registered nurse for units with between 11 and 20 beds. The CRCU was compliant with this standard. The supernumerary nurse provides senior oversight of the unit and support for staff.

In the CRCU at the time of our inspection the trust were compliant with the FICM standard. There were six RN, one HCA and two supernumerary nurse in charge (NIC) during the day with two NIC and six RNs during the night shift caring for one level three patient, one level two patient and three ward ready patients.

Newly qualified nursing staff were supernumerary for six weeks to ensure they could develop basic skills and competencies to safely care for critically ill patients. This was in line with the FICM national standards and was an increase since our last inspection when the supernumerary period was only four weeks.
Nursing handovers took place at the beginning of each shift and named nurses handed over to the incoming named nurse for the shift at the patient’s bedside. Shift handovers included discussions around staffing levels and bed occupancy. Nurse to nurse handover covered any changes in patient observations, patient medications and the patient’s care plan. Nursing staff recorded handovers and signed and dated them.

The nurse led trust wide critical care outreach team (CCOT) was fully staffed with eight WTE band seven nurses and the service provided 24-hour service seven days per week.

Nursing staff told us they were frequently called to assist nurses on other wards. Records of nurse moves showed this happened on 17 days in August, 20 days in September, eight days in October and two days in November 2017. Data supplied by the trust showed CRCU bed occupancy for September 2017 was 80%, October was 81% and November was 85%. Senior nursing staff told us nurses were only released to assist on the wards if patient care on CRCU was not affected.

Medical staffing

Care in the CRCU was led by a consultant intensivist, in accordance with the faculty of intensive medicine (FICM) standards.

The trust has reported their staffing numbers below for the period April 2017 to July 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>1.25</td>
<td>1.26</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

CRCU had one whole time equivalent (WTE) consultant vacancy at the time of our inspection.

Bank and locum staff usage

During the reporting period August 2016 to July 2017 263 shifts were filled by bank medic staff. Doctors in training covered the largest number of shifts (200), consultants covered the smallest (13), and middle grade doctors covered the remaining 50 shifts.

The consultant to patient ratio was 1:12. This was compliant with the FICM standards for intensive care units, which state that consultant/patient ratio should not exceed a range between 1:8 and 1:15 to ensure patient safety.

The unit was fully staffed with eight consultants, one was a long term locum. The lead consultant was registered with the FICM and had anaesthetic involvement. This was compliant with the FICM Core Standards that the consultant lead needs to be FICM-registered.

Daytime medical staffing arrangements were one consultant, two foundation year one (FY1) doctors, one registrar and one or two additional core trainees (CT) year one or two.

A resident registrar or middle-grade doctor provided medical cover out of hours during evenings and weekends with the support of the ITU consultant on call.
The consultant participating in the on call rota was exclusive to CRCU and did not undertake responsibility for delivering other services in the hospital.

The lead CRCU consultant led twice daily ward rounds with input from junior doctors. Nursing staff told us that consultant-led ward rounds took place daily around 8am to 9am. However, when we visited the HDU around 11am the ward round had still not taken place. Nursing staff told us that delays in consultant reviews can occur if there is clinical pressure within the unit or in the hospital as a whole.

Consultant entries in all the medical care records we reviewed evidenced that consultants carried out ward rounds twice a day.

Medical handovers took place at each shift change using a computer-generated handover document. There was no formal handover between the ITU and HDU staff but the same staff rotated between the two units so this allowed continuity of patient care.

**Records**

During the inspection, we reviewed six patient medical care records. The CRCU nursing and medical staff used paper patient care records.

All six of the patient medical care records evidenced that consultants assessed patients within 12 hours of admission to the CRCU as recommended by national standards set by the Faculty of Intensive Care Medicine (FICM). This was an improvement since our previous inspection where we found consultants were inconsistent in recording patient assessments in patient care records.

Nursing and medical staff used different colour paper to make records of care interventions. For example, significant discussions with family were recorded on blue paper so they were easily identified in the patient record while all other CRCU records were recorded on yellow paper.

In the ITU, nursing staff kept patient care and medical records at the patients’ bedside. This was acceptable as patients were never left unattended. In the HDU patient records were stored in an unsecured mobile drawer unit beside the nurses’ station and were easily accessible to visitors. We raised this with senior nursing staff at the time who acknowledged this was not good practice but told us the ward was too small to bring in a records trolley and nursing staff were always in the vicinity.

Nursing staff carried out monthly record keeping audits. For the three months prior to our inspection, the CRCU was 100% compliant. This exceeded the trusts target of 95%.

Nursing staff completed do not attempt cardio pulmonary resuscitation (DNACPR) orders and medical staff reviewed and signed them. We observed three DNACPRs all three were signed, dated and evidenced discussions with family members.

Nursing staff completed mental capacity assessments (MCA) and deprivation of liberty safeguards (DoLS) for patients who they believed lacked capacity. Nursing staff clearly documented conversations with patients and family and signed and dated them.

**Medicines**

Nursing staff across the CRCU managed medicines with regard to handling, storage, security and administration appropriately. This was an improvement since our last inspection where we found nursing staff were not storing medicines appropriately.
Nursing staff carried out monthly audits of medicine management. For the period June 2017 to November 2017, compliance was 100%. This exceeded the trust target of 95%.

The CRCU had a pharmacy storeroom. Nursing staff accessed the room via a coded key pad. The room was clean and tidy and all lockable cupboards were secure.

The trust had a CRCU specific pharmacist. This was a new appointment since our last inspection and assured us there was oversight of medicine management on the CRCU where there had not been at our previous inspection. The pharmacist was available Monday to Friday from 8am until 5pm. The pharmacist attended patient nursing handovers and ward rounds daily.

Pharmacy staff provided each patient on the CRCU with a CRCU specific prescription and infusion chart. Nursing staff completed records and signed and dated the infusion chart and there was clear evidence of pharmacy review and input.

The ward pharmacist was available Monday to Friday 8am until 5pm with an on call pharmacist from 5pm until 9am and at weekends.

The ward pharmacist completed full medicine reconciliation for all patients within 24 hours of admission during weekdays, and within 72 hours if the patient was admitted over the weekend. We saw the pharmacist had completed medicine reconciliation in all of the patient care records we reviewed.

Nursing staff recorded the allergy status for each patient on the front of their prescription chart and in their medical care record. We noted allergy status documented in all the records we reviewed.

Nursing staff prepared intravenous drugs (IVs) and a second nursing staff member checked them before they were administered to the patient. All prescription charts we reviewed were double signed to evidence they had been checked.

The pharmacy used the medusa national database for prescribing of IV medicines this ensured the most up to date information on medicine compatibility, dilutions, and timings.

Pharmacy staff clearly documented dose, duration and clinical indication in the prescription charts of those patients who were on antibiotics. Pharmacy staff used green stickers to highlight this in the patient record.

The trust microbiologist reviewed patients who had been prescribed antibiotics. There was evidence of microbiology input in all the patient care records and prescription charts we reviewed.

One prescription chart we reviewed evidence nursing staff were administering alcohol withdrawal medicines to an alcohol dependent patient in order to control the side effects of alcohol withdrawal.

Nursing staff stored controlled drugs in a locked cupboard within a locked cupboard. Two nursing staff checked controlled drugs (CDs) stock levels at the start of each shift. This was an improvement from our last inspection where we were concerned about poor CD security.

Nursing staff secured medicine trolleys to the wall when they were not in use.

Nursing staff monitored daily fridge temperatures for the fridges in CRCU and for the main fridge in the pharmacy store. There were no omissions in any of the records for September, October and November 2017. This was an improvement from our last inspection where we were concerned about nursing staff consistently not monitoring and recording fridge temperatures.
We found one medicine item was out of date by three days in each of the CRCU resuscitation trolleys, one trolley on ITU and one trolley on HDU. We raised this with nursing staff who removed the item and replaced it immediately.

The CD register on the HDU showed nursing staff transferred CD stock to other wards. For example, a full box of Oxycodone Injection had been given to Penn Ward and Alfentanyl to Tye Green ward. We spoke with nursing staff who confirmed that out of hours CDs are transferred at the discretion of the on call pharmacist and the site manager and the receiving ward brings their CD book to the ward and nursing staff transfer CDs from one book to the other.

Nursing staff kept a record in the pharmacy room of any non-CDs, which had been transferred between wards out of hours. Two nurses recorded the name and quantity of the drug, its destination ward and signed and dated the record.

The CRCU had recently (October 2017) implemented a secure medication return bin, which meant staff could return any unused medicines on the unit to the pharmacy for recycling or disposal. In the first month of use the bin had saved the hospital £1200 by recycling unused medicines.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2016 to September 2017, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in Critical Care, which met the reporting criteria set by NHS England from October 2016 to September 2017.

(Source: Strategic Executive Information System (STEIS))

Nursing staff understood their responsibilities to report incidents and raise concerns. All 14 of the nursing staff we spoke with could describe how to raise an incident on the trust wide electronic reporting system.

All the nursing staff we spoke with told us they were strongly encouraged to report incidents and raise concerns.

We were shown an incident form raised in response to an incident in which a patient had taken a knife from the ward kitchen. The CRCU leads took immediate action and arranged for fitting of a key code lock to the kitchen door. The incident form was clear, detailed, and shared with the serious incident group (SIG).

At our previous inspection, we were concerned about the lack of sharing of learning from incidents. Since then, the CRCU have made improvements and introduced processes for sharing incident outcomes and learning with all staff.
Nursing staff discussed incidents at safety huddles during each shift. Safety huddle records on the 1 December 2017 evidenced the sharing of incidents and learning from investigations with the staff team.

Senior nursing staff displayed details of incidents, their outcomes and actions on a notice board in the seminar room on a week-by-week basis. We reviewed ward team meeting minutes, October 2017, and noted nursing staff discussed incidents.

All nursing staff received a monthly email called the critical care bulletin. We reviewed the email for September 2017, which showed sharing and learning from incidents.

Nursing staff described how they had changed procedures after a number of patients undergoing non-invasive ventilation developed facial sores. This evidenced learning from incidents and near misses.

Nursing staff displayed posters describing incidents, which had occurred in other areas of the hospital and their outcomes as a way of sharing learning from incidents.

The CRCU clinical lead led multidisciplinary team (MDT) morbidity and mortality meetings twice a week and displayed minutes from the meetings in the seminar room to share the learning. We reviewed the minutes of the meeting dated 1 December 2017 and noted the MDT discussed the care provided to three patients and identified it as appropriate.

The lead consultant led monthly reflective mortality and morbidity meetings where nursing staff chose the subject or incident they wished to discuss. All the nursing staff we spoke with told us these meetings were a great opportunity for learning. We reviewed the minutes of the meetings held in March, May and September 2017. There was clear evidence of learning from specific incidents.

We spoke with four nursing staff and one doctor about the duty of candour regulation. 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 provides reasonable support to that person. However, at the time of our inspection CRCU staff had not needed to apply this regulation.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported four new pressure ulcers, no falls with harm and one new catheter urinary tract infection from October 2016 to October 2017.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Princess Alexandra Hospital NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Pressure ulcers (4)</th>
<th>Total Falls (0)</th>
<th>Total CUTIs (1)</th>
</tr>
</thead>
</table>

(Source: NHS Digital)

The ward matron displayed safety thermometer data for November 2017 in the entrance corridor to the CRCU. The data showed there had been no avoidable pressure ulcers (PUs) for 270 days, and there had been no falls for 65 days. The data also showed there had been 24 no-harm incidents during November 2017.

The CRCU team meeting minutes, 16 November 2017, evidenced nursing staff discussed ward safety thermometer performance.

**Is the service effective?**

**Evidence-based care and treatment**

Nursing and medical staff delivered care in line with national standards and evidence based guidelines for example the National Institute for Health and Care Excellence (NICE) guidelines for venous thromboembolism (VTE), the faculty of intensive care medicine (FICM) standards for intensive care units and medusa national database for prescribing intravenous (IV) medicines.

Information provided by the trust stated “the trust uses web based software, NICE Assure, to track status of NICE guidance. The Chief Medical Officer reviews newly issued guidance on a monthly basis and allocate them to healthcare groups (HCGs) to review if applicable and assess compliance.”
The unit used the East of England quality indicators to monitor patient data. They also participated in the Intensive Care National Audit Research Centre (ICNARC) Case Mix programme, National Cardiac Arrest Audit and Aston Organisation Development Team Effectiveness Audit (measurement of effective team practice on a critical care unit. Internal performance monitoring was done through a joint surgery and critical care dashboard.

Nursing staff carried out a number of local audits within the department, for example, staff compliance with the ventilator care bundle and rehabilitation audit.

The unit used the Confusion Assessment Method for the ICU (CAM-ICU) tool to screen patients for delirium in accordance with the FICM national standards. This involved a series of assessment questions for awake and alert patients. Identifying and managing delirium is important for critically ill patients, as it had been linked to longer stays in hospital and prolonged neuropsychological disturbances after leaving intensive care. Audit data from June 2017 to November 2017 showed that staff on the CRCU achieved 100% compliance with the CAM-ICU scoring standard.

The CRCU was compliant with the NICE Clinical Guideline 83 (rehabilitation after a critical illness) as the trust had a specific rehabilitation care pathway. All patients who had stayed in the unit more than five days were invited to attend a nurse led follow up clinic with input from a consultant and a counsellor. Nursing staff answered patients’ questions and could arrange for patients to visit the unit if they wished.

The CRCU staff ensured patient information was communicated with other relevant care providers, and had a follow-up system for longer-term patients, led by the clinical care outreach team (CCOT). Patients at risk of morbidity were assessed by a physiotherapist and had a comprehensive reassessment before being discharged from the unit.

Nutrition and hydration

Nursing staff on the CRCU met patients' nutrition and hydration needs in line with NICE QS15 statement 10; patients have their nutrition and hydration needs regularly assessed and nursing staff weighed patients accurately using a multipurpose hoist.

Nursing staff carried out malnutrition universal screening tool (MUST) risk assessments for all patients admitted to the unit and reviewed them on a weekly basis. We reviewed MUST documents in all the medical care records we reviewed. Nursing staff completed them correctly and signed and dated them.

Nursing staff completed fluid balance charts for patients who were catheterised. Nursing staff completed records accurately and signed and dated them.

The trust wide dietician was available Monday to Friday 8am to 4pm and visited the CRCU on a twice-weekly basis to review patients’ dietary requirements. The dietician documented reviews in patients’ medical care records. Nursing staff told us they could contact the dietician to arrange extra visits if they had concerns about a patient.

Nursing staff provided nutrition to patients who were unable to take an oral feed in line with guidelines for the provision of intensive care services, 2015. These patients had Total Parenteral nutrition (TPN) nutritional support under direction and review of the dietician.

The TPN team were available to assist nursing staff and prepare TPN feeds between Monday and Friday from 8am until 5pm.
Pain relief

The unit had access to a multi-professional clinically led acute pain service and used the hospital pain scoring system, which was led by anaesthetists.

Nursing staff assessed and managed patients’ pain in line with NICE QS 15 statement 10; patients have their pain relief regularly assessed and managed.

The CRCU implemented the faculty of pain medicine’s core standards for pain management 2015. The lead consultant supervised patients’ pain management and this was discussed and documented at each ward round.

Nursing staff used the clinical pain observation tool (CPOT) tool for pain management in those patients who were not able to communicate or living with dementia.

Nursing staff told us they were confident in managing patients’ pain and during our inspection we heard nursing staff asking patients if they were ok or had any pain.

Nursing staff recorded pain management in the patient medical care records.

Patient outcomes

The trust monitored patient outcomes in divisional mortality and morbidity meetings and clinical governance meetings and regularly reviewed the effectiveness of the service by regular participation in national audit. The CRCU was performing comparably to similar units nationally.

ICNARC Participation

The trust has one unit, which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2015/16 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNARC report for April 2016 to March 2017 showed that the unit consistently had mortality rates within the expected range or below. CRCU admitted 680 patients during the 12-month period; two patients died (0.35). 98.6% of patients were discharged from the unit. One per cent of patient outcomes were unknown.

ICNARC data showed that, between April 2016 and March 2017 1.6% of admissions to the CRCU were unplanned readmissions within 48 hours of discharge. This was slightly worse than the average rate on similar units (1.2%).

Hospital mortality (all patients)

For Intensive Care/High Dependency Unit at Princess Alexandra Hospital, the risk adjusted hospital mortality ratio was one in 2015/16. This was similar to the England average. The figure in the 2014/15 annual report was 1.1.

(Source: Intensive Care National Audit Research Centre (ICNARC))
Hospital mortality (for low risk patients)

For Intensive Care/High Dependency Unit at Princess Alexandra Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.1 in 2015/16. This was about the same as the England average. The figure in the 2014/15 annual report was one.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The CRCU performed local audits monthly around record keeping, delirium and safeguarding, medicine management and infection prevention and control (IPC). For the three months prior to our inspection, the CRCU was 100% compliant with record keeping, delirium and safeguarding, medicine management and IPC against the trust target of 95%.

Data provided by the trust showed that between April and July 2017 the trust admitted all patients to CRCU within four hours once the decision to admit had been made. This was in line with ICNARC standards.

Medical records we reviewed evidence consultants reviewed patients within 12 hours of admission to CRCU. This was in line with provision of intensive care guidelines 2015.

If necessary, and to ensure continued compliance following local audits, the trust developed action plans to continue to develop and improve.

Competent staff

Appraisal rates

From July 2016 to August 2017, 79% of staff within critical care at the trust had received an appraisal compared to a trust target of 90%.

The trust did not provide this information by staff group.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At the time of our inspection, December 2016, 95% of nursing staff (57 out of 60 staff) and 100% of critical care medical staff had received an appraisal this exceeded the trust target, which was an improvement on our last inspection where only 29% of staff had received an appraisal.

The CRCU had a clinical nurse educator who was responsible for coordinating the education and training of staff and pre-registration student nurses.

Nursing staff newly recruited to CRCU were supernumerary for a period of six weeks in order to allow time to establish competencies and complete the induction programme.

We reviewed the induction record for one staff member and topics covered included PUs, equipment training, medicines management among other things. Nursing staff signed and dated staff induction records.

Staff completed competency assessments relevant to their role and we saw evidence of these being monitored with up to date charts. We reviewed the CRCU competency folder. Nursing staff and training staff signed and dated records to evidence receiving training and attaining competency. This was an improvement since our last inspection where we found poor record keeping around staff competencies.

The CRCU followed the national competency framework for developing nursing competencies. Senior nursing staff reviewed staff competencies at the staff mid-year review and annual
appraisal to identify any required learning.

The CRCU education lead arranged four one-day training sessions per year for each staff team. Training days were compulsory as part of the nurse rota. Topics covered included use of equipment, delirium scoring and topic suggested by staff members.

Nursing staff received hands on training on any new equipment used on the unit from the company supplying it. For example, nursing staff received ventilator training in April 2017.

The CRCU had link nurses for pressure ulcers (PUs), infection prevention and control (IPC) and safeguarding. Link nurses maintain up to date knowledge of their specialty, promote evidence based practice and act as a link between the multi-disciplinary team and the specialist team.

The CRCU organised an annual national critical care conference day. Expert speakers attended to discuss developments in critical care and a previous patient shared their experience of time in the unit. All the nurses who had attended the day spoke positively about it.

The trust encouraged health care assistant (HCA) staff to undertake higher education and provided study days in order that staff could have time to benefit from their further training. At the time of our inspection three HCA were undertaking nurse training.

Junior doctors attended weekly formal teaching sessions with a timetable of relevant topics. Consultants ensured junior doctors received bedside teaching sessions. The junior doctors we spoke with were positive about the training they received.

In CRCU 54% of nurses, 31 out of 57, with three nurses part way through the course, held the post registration award in critical care. This was better than the guidelines for the provision of intensive care services 2015, recommendation which stated a minimum of 50% of nursing staff should hold the qualification.

**Multidisciplinary working**

Staff from different teams, for example occupational therapy and physiotherapy were involved in assessing, planning and delivering patient care.

The lead consultant led twice daily ward rounds attended by the patients named nurse, the nurse in charge (NIC), the ward pharmacist and the ward doctors. A microbiologist also attended the ward round two to three times per week.

Physiotherapists did not attend ward rounds but received handover from the NIC.

Physiotherapists provided rehabilitation to patients in both ITU and HDU on a daily basis Monday to Friday and the on call physiotherapist attended the unit at weekend to continue patient rehabilitation.

All six of the medical care records we reviewed evidenced input and reviews from the dietician, the physiotherapist, the pharmacist, speech and language therapists (SALT) and the microbiologist. This was an improvement since our last inspection where we found no evidence of dietician input in any of the patient care records we reviewed. Consultants documented clear treatment plans for patients in all of the medical care records.

Mental health nurses reviewed patients when they were medically fit for discharge to a ward in order to assess their mental health. We observed a mental health nurse chatting with a patient and planning their ongoing care for when the patient was in the next ward.

The CCOT reviewed all patients once they had been discharged to ward to ensure a smooth handover of patient care.
At the time of our inspection senior ward staff and consultants were in the process of writing patient discharge guidelines.

The trust told us they had developed trust wide partnership working with a local council to provide care for vulnerable adults.

Seven-day services

Critical care services were delivered seven days per week in line with guidelines for the provision of intensive care services 2015.

Consultants worked block shift patterns to ensure continuity of care for patients. A consultant and registrar were available seven days a week and two or three FY1 doctors five days a week. At night an on-call consultant was available to attend the unit within 30 minutes which was in line with guidelines for the provision of intensive care services 2015.

The unit received support from the critical care outreach team (CCOT). The CCOT nurses were available 24 hours a day seven days per week.

The CCOT reviewed all patients discharged from ITU and HDU at least once daily until they were clinically stable. The CCOT also took referrals of acutely deteriorating ward patients following triggering of the National Early Warning Score (NEWS) tool in other hospital areas. CCOT attended all cardiac arrests and undertook root cause analysis (RCA) on each one. CCOT nurses accompanied any patients who were being transferred to tertiary centres.

Physiotherapists provided CRCU patients with physiotherapy seven days per week. There were two dedicated CRCU physiotherapists available Monday to Friday and the on call physiotherapist attended the CRCU patients at the weekend to carry out their rehabilitation.

Health promotion

Physiotherapists used white boards above patients’ beds to record targets set and goals achieved. Nursing staff told us this meant they could assist patients with working towards their goals. One relative told us they liked to look at the board to reassure themselves their family member was getting better.

Nursing staff encouraged patients to get out of bed where possible and to complete the exercises recommended by the physiotherapist.

Staff could refer patients to the trust wide smoking cessation team, the weight management clinic and mental health team to promote their health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust did not report against the mental capacity act (MCA) or the deprivation of liberty training for staff within critical care.

(Source: Trust Provider Information Return)

We spoke with three medical and three nursing staff about their responsibilities in line with the mental capacity act. Nursing staff told us about best interest decisions and when they would complete MCAs and seek support from the ward safeguarding champion.
The CRCU had a safeguarding champion who was available to assist nursing staff with the completion of MCA and DoLS, however, nursing staff were confident in carrying out mental capacity assessments.

In a review of patient notes, we found that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards assessments were completed appropriately.

Nursing staff evidenced communication with the patient’s family in gaining consent in the patient records we reviewed.

Nursing staff completed delirium assessments daily where appropriate and recorded their findings in the patient’s medical care record. At the time of our inspection, staff compliance with the delirium standard was 100%.

**Is the service caring?**

**Compassionate care**

All the staff we observed treated patients with dignity, respect, kindness and courtesy in line with national institute for health and care excellence (NICE) QS 15 statement 1.

The lead consultant at the multidisciplinary team (MDT) ward round introduced each team member to the patient by their name and their role. This was in line with NICE QS15 statement 3.

Staff closed curtains around patient’s bed space before performing any care to protect the patients’ privacy.

Nursing staff asked patients “Is it ok if we” before carrying out care, for example when repositioning a patient. Nursing staff described what they were doing and reassured the patient throughout the process.

Nursing staff took time to chat with patients about their family and showed a good knowledge of the patient’s life outside of hospital. For example, we heard a nurse asking a patient “Is your son coming up today or is he still away?”

We heard nursing staff sharing appropriate humour with a patient and their relative. We observed another nurse hugging a relative who was distressed.

All the relatives we spoke with described the care provided by nursing staff as “Exceptional” or “First class.” One patient told us that their named nurse was “Amazing” and “Knew I needed something before I even had to ask.”

CRCU staff collected patient feedback. Feedback cards asked “What did we do well?” and “What could we do better?” All the feedback cards we reviewed were positive about care on the unit.

**Emotional support**

A trust wide chaplain supported the unit and staff offered this service to patients and relatives. One relative we spoke with told us they had been offered access to a chaplain.

Nursing staff displayed a flow chart where of guidance on how to arrange spiritual support for relatives and patients regardless of their faith or non-faith.

Staff on CRCU had access to a mental health liaison team. Nursing staff told us they responded in a timely manner when requested.
The staff described how they offered relatives tea and coffee if they seemed distressed and showed them to the family room where they could be private if they wished.

The trust told us the chaplaincy service was also available to help staff members deal with work related stress, relationships and personal issues.

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

Staff routinely involved patients and their relatives in care planning and decision making and this was evidenced in the discussions we reviewed in the patients’ medical care records.

Nursing and medical staff recorded conversations with family members on blue paper so they could easily be identified in patient medical care records. All six medical care records had detailed evidence of conversations with family members.

At multi-disciplinary team (MDT) ward round we observed the consultant asking the patient if they were happy with what had been discussed and whether they had anything they would like to ask or to add. This was in line with NICE QS15 statement 5.

The CRCU had an organ donation champion and displayed their contact details on the information board. Staff and relatives could contact them to discuss a patient’s organ donation wishes.

All three of the relatives we spoke with told us they had been included in care planning and decision making for their relative.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Services provided by the critical care unit (CRCU) reflected the needs of the population it served were flexible and provided continuity of care.

The critical care leads worked with the trust board to reduce the numbers of admissions to the unit wherever possible by using the critical care outreach team (CCOT) to review patients in other areas of the hospital with the aim of preventing admissions to CRCU.

The unit ran follow-up clinics for patients who had spent five or more days in the unit and the CCOT was involved in referring patients to appropriate post-treatment counselling or community services where required.

The trust had negotiated reduced accommodation rates with local hotels for the families of patients cared for in the CRCU along with reduced rates of hospital parking.

**Meeting people’s individual needs**

The HDU only had one bathroom and toilet for those patients on CRCU who become a level one ‘ward-able’ patient no longer requiring the same level of complex care. This meant male and female patients had to share toilets and patients had to pass patients of the opposite sex to reach the bathroom. This constitutes a mixed sex breach. The Chief Nursing Officer and Deputy NHS Chief Executive required providers to declare by 1 April 2011 that all hospital accommodation is same-sex. The requirement covers sleeping accommodation, bathroom/toilet accommodation.
The trust reported mixed sex accommodation (MSA) breaches to the local clinical commissioning group (CCG) and MSA was identified on the trust wide risk register. Data supplied by the trust reported 23 MSA breaches for the period June 2017 to October 2017, an average of four per month. During our inspection, there was a MSA breach on the HDU. Senior CRCU nursing staff told us that there had been three MSA breaches in November.

Nursing and medical staff acknowledged MSA was not an ideal situation. We raised our concerns with the matron who assured us the senior executive team were aware of the difficulties the aging hospital estate created. The board assurance framework (BAF) November 2017, evidenced the board were aware of the MSA breaches caused by the aging estates infrastructure.

Nursing staff had access to a translation service 24 hours a day for patients whose first language was not English.

Nursing staff displayed information for relatives and carers on a board in the CRCU and in the visitors’ room. This included contact details of link nurses for particular requirements such as dementia or nutrition.

Ward orderlies supported patients to choose meals from the menu and offered patients and their visitor’s tea, coffee and snacks. The patient menu offered meals which would meet the needs of those patients with allergies, who were vegetarian or who had specific religious or cultural beliefs.

Nursing staff enforced the trust wide protected mealtimes initiative. This meant no non-essential interventions took place during meal times and allowed patients to eat in peace.

Visiting hours on the ITU were between 3pm and 8pm. On HDU, visiting times were 3pm to 4.30pm and 6.30pm to 8pm.

The CRCU had a designated overnight room for use by the patient’s families. The room had a sofa bed, tea and coffee making facilities and an en-suite shower room. Families could use the room if they had far to travel or needed to be close by. This was an improvement since our last inspection where facilities for families staying on the unit were limited.

The CRCU had a family sitting waiting room. The room had previously been used as an isolation room and was therefore equipped to accommodate a patient. Nursing staff told us they could temporarily reinstate this room to provide end of life patients and their family with privacy if they did not want to go to the end of life ward. However, this had not yet been necessary.
Access and flow

From September 2016 to August 2017, The Princess Alexandra Hospital NHS Trust has seen adult bed occupancy decline, this is better than the England average.

**Adult Critical Care Bed occupancy rates, The Princess Alexandra Hospital NHS Trust.**

![Chart showing adult critical care bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

Data supplied by the trust showed CRCU bed occupancy for September 2017 was 80%, October was 81% and November was 85%.

*(Source: NHS England)*

Delayed discharges

For intensive care/high dependency unit at Princess Alexandra Hospital, there were 3,294 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 12.3% in 2015/16. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 11%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

Non-clinical transfers

For intensive care/high dependency unit at Princess Alexandra Hospital, there were 643 admissions, of which 0% had a non-clinical transfer out of the unit in 2015/16. Compared with other units this unit was about the same as the England average. The figure in the 2014/15 annual report was 1.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

Non-delayed out of hours discharges to the ward

For intensive care/high dependency unit at Princess Alexandra Hospital, 6.4% of admissions were non-delayed, out-of-hours discharges to the ward in 2015/16. These are discharges which took place between 10pm and 7am. Compared with other units, this unit was about the same as the England average. The figure in the 2014/15 annual report was 3.9%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*
Data supplied by the trust showed between June 2017 and October 2017 CRCU discharged 25 patients to ward between 10pm and 7am, an average four patients per month. Overnight discharges are not best practice because patients transferred from CRCU still remain vulnerable and may require additional monitoring in the new area until they are settled.

In August 2017, one patient was readmitted from the ward to CRCU, September 2017, two patients and October 2017, one patient. A high rate of unplanned readmissions from ward to CRCU would be suggestive of premature or incorrect discharges to ward. The number of patients readmitted to CRCU from wards was consistently low.

The number of elective admissions cancelled by the CRCU due to lack of bed availability was consistently low. July 2017, one cancelled, August 2017, none cancelled, September 2017, two cancelled and October 2017 none cancelled.

Bed occupancy issues were regularly discussed at team meetings and were highlighted as a concern by all staff groups during our inspection. The CRCU was only funded for five beds intensive treatment beds but regularly had to open the full seven beds.

Meeting minutes dated November 2017 showed clear consideration of discharge arrangements and evidence that staff were reminded not to accept patients as ward-able until a doctor documented it. Patients could then be treated as Level 1 and follow the discharge pathway.

Nursing staff told us that getting patients discharged to a ward was difficult due to beds not being available. Nursing staff described how sometimes patients had been discharged straight home. The CCOT told us this was not good practice and was very unusual. Data provided by the trust showed in the three months, September to November 2017, 24 patients were discharged home from CRCU.

Learning from complaints and concerns

From August 2016 to July 2017 there were no complaints directly made about critical care. There are two that mention ITU/HDU around creating a checklist for end of life patients that are within critical care setting, and the other around delay in treatment.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The CRCU provided feedback cards for patients and relatives and information on how to raise a complaint was available on the information board.

All the relatives we spoke with told us they were aware of how to raise a complaint but felt they were happy to raise concerns with the nurse caring for their relative if they had any.

Complaints and outcomes were displayed on a notice board in the seminar room and minutes of team meetings dated November 2017 evidenced sharing and learning from incidents. This was an improvement since our last inspection where we found poor sharing and learning from complaints.

Nursing staff told us they were developing a list of things to consider with regards to patient wishes if their relative was end of life. This was as result of a previous complaint. For example, do the
family want the bed space curtains open or closed? Would they like to move to the end of life ward or the family room? This evidenced learning from complaints.

**Is the service well-led?**

**Leadership**

The critical care service sat within the surgery and critical care health care group. A clinical director, associate director of nursing and a deputy director of operations led the service.

A consultant intensivist with the support of a matron and senior ward sisters led the critical care unit (CRCU).

All the staff we spoke with spoke positively about the CRCU leadership telling us all leaders were supportive, visible and approachable. This was an improvement on our last inspection where staff told us leaders were not visible, supportive or approachable.

Leadership of the CRCU met the provision of intensive care guidelines 2015 by ensuring there was a lead consultant, a lead nurse and a supernumerary nurse available at all times.

All the staff we spoke with about the recently appointed chief executive (CEO) told us they felt there was a positive change in the culture of the hospital.

**Vision and strategy**

All four of the nursing staff we asked knew the trust wide vision 'Your future, our hospital' and what it wanted to achieve.

The trust vision was supplemented by five year plans for all of the departments and specialties based on the local PAH five P framework of: - Our Patients, Our People, Our Performance, Our Places and Our Pounds.

Posters were noted on the CRCU with the five Ps and all staff we spoke with knew of the five Ps framework and told us they felt staff lived by it.

The trust had a clear vision for CRCU to be caring, committed, respectful and responsible.

Nursing staff told us their local vision for the unit was to always deliver excellent personal patient care.

**Culture**

The culture had improved since our previous inspection, where we had concerns about the poor culture and lack of accountability around daily checks of things such as emergency trolleys and drug fridge temperature.

All the staff we spoke with described the culture of the CRCU as positive, friendly, optimistic, and honest and they felt respected and valued by team members. This was an improvement on our last inspection where we found staff morale was poor.
Staff consistently reported they felt empowered and confident to raise concerns if they felt the need, and were supported by their managers to do this. There was a positive culture of incident reporting that encouraged learning and improvements in care.

All the staff we spoke with told us they were encouraged to make suggestions for ways of improving the service. For example, a band 5 nurse suggested the different coloured curtains for bed spaces of infectious patients, and a band 6 nurse suggested the drug return bin.

All the staff we asked about training development told us they had been encouraged to attend additional courses. A poster displayed in the seminar room encouraged any staff thinking of leaving employment to approach a named senior trust member in confidence, to advise them on career progression within the trust.

Staff we spoke with cared for one another’s wellbeing and were proud of their team. Nursing and medical staff used “A hug in a jug.” Staff wrote a note to another named member of staff about a specific incident and put it in a jar. At team meeting senior ward staff emptied the jar and gave out the notes. One note said “Thank you for helping me on such a busy shift” and named the nurses involved. All the nursing staff we spoke with were positive about this initiative and told us it gave them chance to let team members know how much they appreciated them.

**Governance**

Governance had improved since our last inspection where we found communication between ward and board was not effective.

The CRCU had structures and processes of accountability in place to support the delivery of critical care. There was an embedded governance structure within medical services. The medical health group and patient safety and quality group meeting were held monthly which reported into the trust committee on patient safety.

The trust had measures in place for ward based risks to be escalated to the trust board. Ward managers completed monthly reports which included the ward based risk register. The risk profile for the wards were managed by the service leads who reported to the trust board.

The health care group held weekly governance meetings that linked in with trust-wide clinical effectiveness committee meetings.

Governance processes for ensuring sharing feedback from complaints and lessons learned from incidents were in place and staff told us they routinely received feedback from incidents reported or complaints received.

Senior ward sisters led weekly ward team meetings. Matron led senior sisters meetings and attended meetings with the head of nursing. Ward team meeting minutes (July 2017) along with sisters meeting minutes (July 2017) evidenced ward to board and board to ward communication.

**Management of risk, issues and performance**

The trust had systems for identifying risks and planning to eliminate or reduce them.

The trust had 30 items on the CRCU risk register. Items on the CRCU risk register were discussed in governance meetings and updated as needed and all risks had review dates and action plans. There were monthly risk committee meetings. Matrons, ward managers, service leads and senior
staff could add or edit their own area risks and enable better oversight of CRCU risks as a whole. Training on how to use the risk system Assure, was being rolled out. The top risks were: staffing, the estate and finance.

Risks identified by staff on the risk register matched those risks we identified during the inspection. This was an improvement on our previous inspection where some risks were missing from the risk register.

The CRCU had systems in place for managing current performance. Nursing staff reviewed performance monthly via the quality indicators audit results including infection prevention and control (IPC).

Nursing staff told us about their local worry list, for example the high dependency unit (HDU) being small and the shortage of nursing staff. All the concerns nursing staff identified had been recorded on the trust board assurance framework (November 2017) with mitigating actions, named lead and review dates.

Senior ward nurses carried out monthly audits to identify areas of concern. Nursing staff told us about previously poor compliance with delirium risk assessments. Nursing staff completed additional training around delirium scoring and for the six months prior to our inspection compliance has been 100%.

**Information management**

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via paper patient records and the staff intranet.

The trust used an electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

**Engagement**

The CRCU collected patient and relative feedback anonymously via comment cards posted into sealed letter boxes. Feedback cards asked patients and their relatives to state “What we did well” and “What could we do better” in order to improve the service. This was an improvement since our last inspection where we found collection of patient feedback was poor.

The critical care outreach team (CCOT) had been nominated for a hospital wide award. One CCOT member told us this had made them feel very proud and valued.

The trust chief executive officer (CEO) invited all staff to attend a Tuesday morning executive team briefing held in the hospital canteen. The CEO encouraged all staff to raise any questions or concerns directly to them.

The CEO sent weekly hospital wide staff updates and had a dedicated email address so staff could contact them directly. None of the staff we spoke with had done this but told us this was because they had not needed to rather than because they felt they couldn’t.

Nursing staff gave anonymous feedback on the consultant of the week. This was an improvement since our previous inspection where we found collection of staff feedback was poor. Staff scored
the consultants performance on the training they provided and communication among other things. Each consultant performance was compared score charts created. The consultant told us they used the feedback for personal development.

Staff spoke positively about the September 2017 'Event in a tent'. The trust had a marquee in the hospital grounds to launch the 'Your future, our hospital' improvement plan. The event was open to staff, the local community and stakeholders.

The unit ran follow-up clinics for patients who had spent five or more days in the unit and patients and their family were encouraged to feedback on their experience during their time in the CRCU.

**Learning, continuous improvement and innovation**

The trust promoted learning, and access to leadership courses were available.

Nursing staff told us they were constantly supported and encouraged to identify new and better ways of working on CRCU.

Nursing staff had recently implemented the drug returns bin, which had contributed to financial savings across the trust.
Services for children and young people

Facts and data about this service

Services for children and young people comprised an inpatient children’s ward, neonatal unit, day surgery service, and children’s outpatients. The trust has 20 inpatient paediatric beds in total on Dolphin ward, for patients up to 16. Patients aged 16 or 17 were cared for in adult wards. The neonatal unit has 16 cots, comprising 10 special care cots and six intensive therapy or high dependency cots. The neonatal unit provides level two care and supports transfer of babies requiring level three care to specialist units in neighbouring trusts. Children requiring day surgery are cared for in any of the five dedicated children’s beds in the day surgery unit.

The trust had 2,329 spells from August 2016 to July 2017. Emergency spells accounted for 92% (2134 spells), less than 1% (6 spells) were day case spells, and the remaining 8% (189 spells) were elective.

Is the service safe?

Mandatory training

Mandatory training was a combination of online and face-to-face classroom learning and secretarial support staff were responsible for maintaining training records.

At the time of inspection mandatory training compliance rates for Dolphin ward were displayed on a ‘How are we doing?’ information board. The ward was not meeting the trust target of 95% for any of its mandatory training modules. The module with the lowest compliance was blood taking (31%) and the highest was equality and diversity (81%). Data provided by the service following inspection showed the following overall mandatory training compliance for children’s services:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Assignment Count</th>
<th>Required</th>
<th>Achieved</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dolphin Ward</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>22</td>
<td>312</td>
<td>222</td>
<td>71.15%</td>
</tr>
<tr>
<td>Neo-Natal Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>29</td>
<td>428</td>
<td>315</td>
<td>73.60%</td>
</tr>
<tr>
<td>Paediatric Outpatients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td></td>
<td></td>
<td></td>
<td>87.50%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td></td>
<td></td>
<td></td>
<td>62.50%</td>
</tr>
<tr>
<td>Medical Staffing - Child Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>28</td>
<td>224</td>
<td>118</td>
<td>52.68%</td>
</tr>
</tbody>
</table>

We discussed this with the ward manager and they were aware that low training compliance was a concern for the ward. The reason for this was that high staff vacancies meant they had not been able to take staff away from their clinical work for dedicated training time.
This was on the service’s risk register. We saw the mandatory training schedule where staff had been booked onto refresher training sessions over the upcoming months, as a means of addressing this risk.

For agency staff, the agency provided the trust with the mandatory training records and their employment would be capped if they were not up-to-date.

**Safeguarding**

Data valid as of November 2017 showed that 62.5% of staff on Dolphin ward were up-to-date with level three training in safeguarding children compared to the trust target level of 95%. One hundred percent of the community neonatal team (this equated to two members of staff); 77.5% of staff on the NNU; and 75% of staff in children’s outpatients were up-to-date.

We raised this as a concern with the ward manager. They were aware this was a concern and told us the reason for low compliance rates was that low staffing levels and high vacancies meant they had not been able to take staff away from their clinical roles in order to complete refresher training.

Agency staff working on Dolphin ward only had level two training in safeguarding children. The ward manager told us they had been in discussion with leads for the agency staff to undertake level three training but this had not yet happened because it was more of a priority to get substantive nursing staff up-to-date with level three training. The agency staff always worked alongside substantive staff who were level three trained.

However, awareness of potential safeguarding issues and reporting requirements had improved since the last inspection, where we had concerns around safeguarding awareness and understanding. All medical and nursing staff we spoke with were able to give examples of safeguarding concerns they had either reported themselves or which had been shared with them for learning.

There were measures to improve safeguarding awareness in children’s outpatients since the last inspection. For example, staff had implemented a database to closely monitor children who did not attend (DNAs) their booked appointments. If the child was known to social services, outpatients would alert social services to the DNA. If they were not a known safeguarding risk, they would wait until the second or third DNA before alerting social services.

Staff in children’s outpatients underwent quarterly safeguarding-focused supervisions. Two staff were booked to go on a safeguarding referral workshop in December 2017 to improve skills and knowledge around ensuring the most important information was flagged up both internally and to external organisations in the event of a safeguarding concern. A member of staff had been identified to be a safeguarding link nurse for the service and would receive support from the trust safeguarding leads in this role.

Across children’s services, safeguarding huddles were taking place to discuss specific cases of safeguarding concerns and actions taken. These were arranged as and when cases arose.

There had also been an improvement since the last inspection in relation to safeguarding training for staff in theatres and recovery. Previously, no staff in surgery (theatres and recovery) had been trained to level three in safeguarding children, however, at this inspection; we found there were now some staff (24.5%) in theatres trained to level three. Although this was still a low percentage,
it equated to 24 members of staff, so staff always had access to someone who was level three trained. The theatres staff who were not up to date with level three training had been booked for training dates in January, February and March 2018 to complete this. Staff in the post-anaesthetic care unit (PACU) were 73.3% compliant with level three training in safeguarding children (which equated to 11 out of 15 staff).

Awareness of female genital mutilation (FGM) and domestic violence was covered in safeguarding training and staff were familiar about these when we asked them. For example, staff in outpatients told us about a concern they had about a potential domestic violence situation, where they had involved the safeguarding lead and put an alert on the trust electronic database to ensure reception and other staff were aware of the concern.

Twelve leads for child sexual exploitation (CSE) had been identified in various roles and were due to undergo training to take on these lead roles in January 2018 with support from the safeguarding leads. These 12 staff members had a particular interest in this area of work. The safeguarding leads had recently run a CSE ‘awareness stall’ in the reception area of the trust for both staff and the public, and had recently established a quarterly forum on the topic of CSE to discuss updates to legislation and guidance and serious case reviews, to ensure staff continued to be aware of the risk.

Children’s services had five level four safeguarding leads, two level four safeguarding nurses, two level four safeguarding doctors and one level four safeguarding midwife. We spoke with one of the safeguarding leads, who was able to explain some of the recent changes and improvements around safeguarding, as above, and were confident with applying national guidance and good practice in the clinical environment. This person attended medical handovers to ensure they were kept aware of any child who was a potential safeguarding concern.

The safeguarding leads received a report every morning telling them where all the 16 and 17 year olds were in the trust who had been admitted without a parent or carer present, and they would review all these patients (because 16 and 17 year olds were not admitted to the children’s ward). We reviewed the notes for a 16 year old admitted to an adult ward who was experiencing mental health difficulties and saw a safeguarding plan clearly documented, and that the safeguarding lead had met with the patient.

They also told us that in the last 12 months, their links to social services had improved and the waiting time to access a social worker had reduced, even in cases where a child protection plan had not been in place for a patient.

The safeguarding lead told us they were liaising with trust management to build a safeguarding tab into the trust electronic system for patient details which was due to go live in April 2018 for maternity services, before being rolled out further. This would also include an integrated alert system to flag looked after children. At the time of our inspection safeguarding information was stored on a different database and had to be manually inputted to the trust electronic system, which the lead told us was more time consuming and felt that an automated process would reduce the risk of information being overlooked. However, they felt staff mitigated this well through effective handover and documentation processes.

At the medical handover we attended on Dolphin ward, there was appropriate discussion about potential safeguarding concerns for staff to be aware of, for example flagging up that a child admitted on that day had previously not attended (DNA) without reason. Another complex case
involving an adolescent which presented safeguarding queries was discussed and a member of staff allocated to speak to the patient alone. When we spoke with the safeguarding lead, they told us this patient would not be discharged until they had resolved these concerns to ensure the safety of the child.

There were clear flowcharts setting out the safeguarding process for staff to follow displayed on the staff board in the office of children's outpatients; and at the nurses’ stations and staff rooms of both NNU and Dolphin ward.

Children were always offered a chaperone when attending appointments in children’s outpatients in accordance with trust policy.

**Cleanliness, infection control and hygiene**

We observed good practice in infection prevention and control (IPC) throughout the inspection such as regular hand washing, compliance with ‘bare below the elbows’ policy and wearing personal protective equipment (PPE) such as aprons and gloves.

PPE in a range of sizes was available outside side rooms alongside a sign reminding staff about good hygiene practices before they entered the side room.

Waste was appropriately segregated by colour coded waste bins for general waste and clinical waste. Waste was disposed of appropriately in accordance with trust policy. There were sharps bins in all clinical areas, which were labelled to identify when the bin was first used. They were within safe fill limits and closed securely.

Both Dolphin ward and the neonatal unit (NNU) had an infection prevention and control (IPC) link nurse in post. Their role was to coordinate the IPC audits in the environment, liaise with the trust IPC team and attend IPC meetings along with the matron.

On NNU all babies were swabbed on admission and not taken out of incubators until the results were returned.

Hand hygiene monthly audits for NNU showed that between June and October 2017 the unit had performed well, scoring between 97% and 100% compliance. However, this had dropped to 78% for November 2017. The ward manager explained the issues that had been identified, namely that staff were not washing their hands after using personal protective equipment. As an action for improvement, the importance of this was reiterated to staff in safety huddles and handover meetings, and via email. There were plans for spot checks of hand hygiene over the following month to ensure staff maintained compliance with the trust hand hygiene policy.

Dolphin ward had scored between 97% and 100% for hand hygiene compliance between June and August 2017.

Between December 2016 and November 2017, there were no instances of MRSA recorded in the service.

Between December 2016 and November 2017, there were no instances of C.difficile recorded in the service.

In the kitchen on Dolphin ward we saw there were individual steriliser units for bottles, with each patient’s name clearly identified. These were prepared by staff and parents could not access the kitchen to ensure IPC was maintained.
In the CQC children's survey 2016, the trust scored 8.4 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. (Source: CQC Children’s Survey, RCPCH)

**Environment and equipment**

Dolphin ward consisted of 20 beds across seven cubicles and two bays, and included a four bedded ambulatory care bay. The service generally operated with 16 beds but had the capacity to flex up to the additional four as required. The cubicles had en-suite facilities and were usually allocated to oncology patients.

The ward was sufficiently spacious, with locked doors which could be accessed by key code, and decorated in a child-friendly way with an ‘under the sea’ theme.

Reception was staffed from 8am to 4pm and there was CCTV at the nurses station.

There was a garden play area which was secure, accessed from Dolphin ward, with outdoor play facilities. This had recently been redesigned by volunteers from the local college, with additional outdoor facilities, flowers and plants to make it bright and appealing to children.

Within the garden there was also a small building reserved for adolescents on the ward. At the time of our inspection it was being used to store the Christmas presents for children on the ward.

There was a sensory room and sensory bathroom on the ward with light and sound systems and a range of multi-sensory toys and activities.

There was a parents’ room in Dolphin ward with four chairs, which was a facility for parents to have some quiet time away from the main ward area. However, it was bare, with no information displayed. There was a kettle and microwave for parents to make food and hot drinks. We were concerned that they were kept on a low table and would be within reach of small children. We were told that the room was for parent use only, however, on the day of our inspection, the door had been propped in and we saw a small child go into the room with his mother. We raised this as a potential safety risk, and the ward manager addressed this immediately by putting a sign on the door of the room stating it was not to be propped open, and also put in a request to the estates department to install a higher work surface for the microwave and kettle so they would be at a safer level.

The neonatal unit (NNU) had 16 cots inclusive of 10 level special care cots and six cots for intensive therapy or high dependency care. It was spacious, free from clutter, and secured by key code access.

Children’s outpatients was contained within a dedicated area within the main outpatients department. The waiting area was small, with eight seats. Staff reported it could often be difficult and cramped when accommodating patients who were accompanied by more than one family member but that they never had to use the adults outpatients waiting room despite capacity issues.

There were two dedicated clinic rooms in children’s outpatients. One did not have examination facilities and the other had two adjoining examination rooms to each side of it. However, the service used the adult outpatient clinic rooms, which were located along the same corridor, meaning there was sufficient capacity for all children’s outpatient clinics. The clinic rooms were allocated in advance to children’s services so adults were not seen in those rooms during clinic
times, although adult clinics did take place in other rooms on the same corridor at the same time. The paediatric consultant always came to collect the patient from the children's waiting room and accompanied them to the clinic room.

We checked the resuscitation trolley on Dolphin ward, NNU and children's outpatients and saw that the contents matched the equipment checklist. The daily checks of these had been completed on the ward and outpatients, and the twice-daily checks completed in NNU, for the previous three months.

This was an improvement from our previous inspection, where we had found that there was a poor culture around checking the trolleys. The ward had recently introduced a new clearer layout of the resuscitation trolley using coloured trays, which they said had helped with this improvement. The service had also implemented weekly ‘double checks’. Double checks were independent second checks by another member of staff not in their immediate team, which had helped to improve accountability in this area.

There was a locked fridge for expressed breast milk on the NNU and Dolphin ward. Daily checks of the fridge temperature had been documented and signed off for the previous three months with no gaps. Daily checks of the fridge for expressed breast milk on Dolphin ward were consistently done for the same time frame. This was an improvement since the last inspection.

Equipment on the NNU was noted as a current risk on the local risk register because a lot of it was coming to the end of its service term at the same time. There had been recent investment in equipment for the NNU, which the service leads highlighted to us as an achievement for the service and was helping to address the risk. This included replacement of continuous positive airway pressure (CPAP) machines and a new transport incubator.

Individual logs of equipment servicing and repairs were kept on Dolphin ward, NNU and children’s outpatients. These identified the equipment being serviced or repaired, the work done on that equipment, the technician’s name and date of service or repair. This was in line with the trust’s own policy for the management of medical devices and equipment.

In the CQC children’s survey 2017, the trust scored 8.3 out of ten for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’ This was about the same as other trusts other trusts. (Source: CQC Children’s Survey, RCPCH)

Fire extinguishers were fixed securely to the wall so they did not present a trip hazard and were all in date.

Assessing and responding to patient risk

The service had a ‘consultant of the week’ who was on call to respond to any concerns over patient risk or deterioration. There was always a registrar on call for all children’s areas so they could respond promptly to any patient deterioration. On the NNU there was a junior doctor at foundation training level one or two available 24 hours a day, seven days a week.

There was always a doctor with advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on each shift.

However, there was low compliance with mandatory training in adult and paediatric basic life support. Data provided by the trust showed that on Dolphin ward, compliance with adults and
paediatric basic life support was 57.89% for registered nurses. In NNU compliance was 58.6% for registered nurses and 50% for additional clinical services. For medical staff across children’s services, compliance with adults and paediatric basic life support was 32.1%.

As of October 2017, compliance with training in paediatric intermediate life support (PILS) was 63.1% across all staff in children’s services. This data was taken from the service’s risk register so we did not see any further breakdown between areas or staff within the service. Within the post-anaesthetic care unit (PACU), 53.3% of staff (8 out of 15) were up to date with PILS training. The others had been booked onto training dates in January 2018.

This was a concern as it meant the service was not meeting standards set by the Royal College of Nursing (RCN), which state, ‘All nurses who provide care to children and young people should be qualified in the nursing care of children and young people’, including ‘Basic and advanced paediatric life support (or equivalent) skills’

At our last inspection in June 2016, low compliance with paediatric life support training was highlighted as an issue, so it was a concern that there had been no improvement in this area. However, service leads were aware of this concern and it was identified on the local risk register. There were mitigating actions for this, including extra PILS dates to enable more staff to complete training, which was an ongoing action commencing August 2017.

We observed two paediatric early warning scores (PEWS) being carried out on the ward to assess patients’ risk of deterioration. One did not document the respiratory rate. Observations were otherwise complete and scored appropriately.

The neonatal unit (NNU) was not using neonatal early warning scores (EWS). However, they were involved with ongoing work in the regional operational delivery network (ODN) to develop a new neonatal alert and track (NAT) tool, which would work in a similar way to identify patients at risk based on behavioural and physiological signals.

To ensure they had oversight of patients at risk of deterioration, the NNU was relying on notes and observations rather than a specific tool. Observations were hourly for high dependency babies and every two to three hours for special care babies. The ward manager and other staff felt this was sufficient to monitor and respond to babies at risk of deterioration and we saw this during our observations. Escalation charts were visible on the walls on the NNU to explain clearly to staff when to contact the consultant in the event of babies deteriorating.

The service had a sepsis assessment tool with checklists under the headings ‘recognise’ ‘respond’ and ‘reassess’ and a clear escalation flowchart for patients identified as being at risk and directions on medicines to administer in the event of an urgent ‘red flag’ case. This was based on best practice and guidance from NICE, the operational delivery network (ODN) and referred to the SORT NHS sepsis pathway.

Sepsis risk for particular patients was discussed at the handover we attended on NNU.

In day surgery during the children’s lists the staff were paediatric trained. However, within the post-anaesthetic care unit (PACU) there were no paediatric-trained staff. Guidance from the Royal College of Anaesthetists (RCoA) states:

“In the period immediately after anaesthesia the child should be managed in a recovery ward or post-anaesthesia care unit on a one to one basis, by designated staff with up-to-date paediatric
competencies, particularly resuscitation. A registered children’s nurse should be directly involved with the organisation of the service and training in this area. A member of staff with advanced training in life support for children should always be available.”

We raised this with the manager of Dolphin ward who told us that, while they would like to have paediatric cover in main surgery at all times, this option had not been considered feasible because children going through main surgery was sporadic. However, once the patient had reached a stable condition in recovery, a paediatric nurse would come down to bring them to the children’s ward.

Data provided by the trust showed that, between June and November 2017, monthly numbers of children cared for in the main recovery area ranged from 51 (4.9% of total patients in recovery) to 127 (11.8% of total patients in recovery)

The ward had introduced a new mental health risk assessment, which included more indicators on factors such as self-harm to help staff recognise patients at risk and their individual triggers. This would then be documented in the patient’s care plan. The ward manager gave a recent example of a child who had not been considered safe to admit onto the ward so they had been treated in a side room of the emergency department to minimise risk to themselves and others.

The entrances to both Dolphin ward and the neonatal unit were locked with secure keypad access and a buzzer system. This meant that there was less risk of children absconding or child abduction. There was an up-to-date trust wide child abduction policy and staff were familiar with this.

Staff were not trained in recognising and responding to mental health difficulties or crises in children, although they told us such children would regularly be admitted. It was identified on the local risk register that ‘staff have limited experience of children with Mental Health needs and have only received basic awareness training in relation to the care for Children and Young People with mental health needs’. There were actions to mitigate this, which were also specified on the risk register. These included improved access to external services to help respond to risks presented by children with mental health difficulties, and plans in place for more advanced training including opportunities staff to shadow the Emotional Wellbeing and Mental Health Service (EWMHS) team for improved understanding.

### Nurse staffing

Data provided by the service prior to inspection showed the following nurse staffing levels for children’s services, as of July 2017. (Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>58.55</td>
<td>52.18</td>
</tr>
</tbody>
</table>

Current staffing levels were displayed on a ‘How are we doing?’ information board on Dolphin ward. At the time of our inspection, this showed the following establishment of nursing staff: four whole time equivalent (WTE) band seven, eight WTE band six, 8.6 WTE band five, 1.5 WTE band four, four WTE band three, and 1.6 WTE band two.
This board also displayed the current vacancies in nursing staff for children’s services. There were no vacancies shown at the time of inspection for band seven, band six and band three staff. For band five nurses there was a vacancy rate of 2.2 WTE nurses; for band four staff, one WTE; and for band two staff, 4.1 WTE.

At the time of our inspection, the ward manager of Dolphin ward was covering the matron role as well as their own, due to maternity leave. They said they often had to step in to do clinical shifts when they were meant to be supernumerary. They told us their planned staffing levels were five registered nurses and one health care assistant (HCA) but their actual staffing levels were usually four registered nurses and two HCAs. Rotas we reviewed for the previous six weeks backed this up.

Despite the vacancies, staff reported they felt able to manage the level of acuity of patients. At the time of our inspection, we observed that staffing was sufficient to meet patient needs. However, staff consistently reported it was their main concern. One member of staff felt HCAs could potentially be upskilled through additional training to alleviate some of the pressure on nursing staff at busy times and the ward manager was looking into this option.

The service mitigated the risk of low nurse staffing on Dolphin ward by being flexible with their workforce between different areas, for example moving staff from the NNU and where possible the paediatric emergency department to help cover the ward, if it was safe to do so. They had also recently recruited a band two ward assistant who was going to be responsible for housekeeping and administrative tasks which the ward manager hoped would alleviate some of the pressure on nurses. Band three care support workers were starting to undergo training on taking blood and breastfeeding, which they hoped, would help to contribute. This was not in line with the Royal College of Nursing (RCN) guidelines.

Current staffing levels for children’s outpatients were as follows: one full time band seven nurse, plus an additional band seven allergy nurse specialist; two part time band five nurses; and two part time HCAs. Staff felt this was sufficient to cover clinic lists and during our inspection, we saw staffing matched patient needs in outpatients.

We saw improvement in nurse staffing levels on the NNU since the previous inspection. The NNU was meeting standards set by the British Association of Perinatal Medicine (BAPM) for nursing staffing levels, and there was always a band six nurse or above leading the shift. During our inspection we saw nurse staffing levels safely met the needs of babies in the unit. We reviewed rotas for September to November 2017 and saw there had only been one occasion where the service had dropped below the BAPM guidelines, which was automatically highlighted in red by the rostering system so the ward manager could see easily how often they were falling below BAPM guidelines.

We reviewed the monthly safer staffing reports for the NNU from June to November 2017, which also reported that the unit was compliant with safe staffing levels, although the nurse in charge was often not supernumerary as recommended by BAPM.

Prior to inspection, the trust reported an annual vacancy rate of 10.3% in children’s services, with a vacancy rate of 28% on Dolphin ward. However, we could not break this down further as it did not show the individual vacancy rates for each staff group. (Source: Routine Provider Information Request (RPIR) P17 Vacancies).

From August 2016 to July 2017, the trust reported a turnover rate of 22.3% for nursing staff in Children and Young People. This was notably higher than the trust’s target of 11%. However, this was not broken down by individual areas and staff groups in order to fully assess turnover. (Source: Routine Provider Information Request (RPIR) P18 Turnover)
Between August 2016 and July 2017, the trust reported an average annual sickness rate of 4% for nursing staff work in Children and Young People. This was slightly higher than the trust’s target rate of 3.5%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

Data provided by the service prior to inspection showed that, between August 2016 and July 2017, 28.6% of shifts for nursing staff within children and young people were covered by bank and agency staff. (Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency).

This was largely due to Dolphin ward using a core group of five regular agency nurses who were considered part of the team and had been fully inducted to the ward. This was backed up by rotas we reviewed from the previous six weeks.

Rotas were planned two months in advance and staff were able to see the shifts they had been booked for on a mobile phone app, as well as on the online portal and on the ward. Agency and bank staff were added into the rota as needed, once the rotas for substantive staff had been completed.

The NNU did not use agency staff but used a core group of their own bank staff to fill shifts if needed.

Medical staffing

The trust has reported their staffing numbers from July 2017 to August 2017.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>WTE Staff</th>
<th>Number in post July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental staff</td>
<td>36.36</td>
<td>36.96</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The trust reported an annual vacancy rate of 10.3% in Children and Young People. Of note is Dolphin Ward, which had a vacancy rate of 28%, although this was a slight improvement from our previous inspection where it had been 30%. The trust has not broken this data out by staff group. This will need to be requested to allow for further analysis into vacancy by staff group.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

There were 32 whole time equivalent (WTE) medical staff working in children’s services. From July 2017 to July 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average (32% compared to 42%) and the proportion of junior (foundation years one and two) staff was higher (16% compared to seven per cent). (Source: NHS Digital Workforce Statistics)

At the time of inspection, there were 11 consultants working in children’s services. The service had recently introduced a twilight shift. A consultant would often step down to cover the registrar twilight shift if needed as we were told that there was not always sufficient registrar staff to cover this.

Within children’s outpatients, cardiology clinics were consultant-led. Allergy, diabetes and oncology clinics were consultant-led alongside the respective nurse specialists. Jaundice clinics were led by a registrar from NNU, and general clinics all had a consultant and registrar.
Parents of children on the ward reported they had adequate access to their child’s consultant for any questions or concerns.

Records

Records were paper-based and stored securely in Dolphin ward, NNU and children’s outpatients to maintain confidentiality.

We reviewed five sets of patient records on Dolphin ward. They were all legible, but variable in what had been completed. For example, only two had the patient’s name and NHS number on every page, and only one record specifically documented a discussion with parents. All five had been signed with the appropriate GMC number included.

We reviewed 10 sets of patient records on NNU. Four of these did not have documentation that there had been a discussion with parents and three did not have the patient’s name and NHS number on every page, but they were otherwise complete.

Medicines

There were pharmacy rooms on the ward and NNU, which were locked securely with key code access. Medicines fridges were locked with coded padlock access. This was an improvement from our previous inspection in June 2016, where we had found that medicines storage cupboards were not sufficiently secure.

In children’s outpatients, there was a locked pharmacy room with key code access. Only antihistamines and epipens, to be able to administer adrenaline in the event of anaphylaxis (a severe allergic reaction), were stored there day-to-day. There was a separate locked fridge in this room used for oncology medicines, and the oncology nurse brought the medicines down from the ward pharmacy to store them here for the duration of the oncology clinics, and then returned them at the end of the clinic list.

Daily checks of medicines fridges were recorded for Dolphin ward, the NNU, and children’s outpatients, for the previous three months, to ensure they were within the safe temperature range. This was supported by audit results from November 2017 for fridge temperature monitoring carried out by the pharmacy team.

If the temperature was recorded as out of the safe range, staff would check again 30 minutes later in case it was a reading error, and if it was still out, it would be reported to estates, taken out of use and replaced. This was an improvement from the previous inspection, which had found a poor culture around daily fridge checks.

Controlled drugs were locked securely and separately from other medicines. The master keys were held by the nurse in charge, with secondary keys in a safe within the pharmacy room in case of emergency. A stock check of controlled drugs was carried out twice daily with two members of staff required to sign this off. We saw this had been done and signed off with no gaps from September to November 2017.

We reviewed a sample drug chart on the ward. This recorded allergies in line with NICE guidance; regular medicines prescribed including route, frequency, all of which were signed by the prescriber with no missed doses recorded.
An audit of drug allergy recording in November 2017 showed that, out of four inpatient prescriptions reviewed on Dolphin ward, all four clearly documented the name of drug or no known allergies, and the nature of the allergy. However, one had not been signed and dated. This caused the ward to score a red/amber/green (RAG) rating of amber on the audit.

In the same audit of drug allergy recording the NNU had scored a green rating as all four records checked had appropriate documentation and sign off.

There was a dedicated paediatric pharmacist, who reviewed all prescription charts for both the ward and the NNU every day from Monday to Friday. Pharmacists had access to patient summary care records. A pharmacist completed the full medicine reconciliation for all patients within 24 hours of admission during weekdays, or within 72 hours of admission on weekends.

All medicines administered to children were double checked by two qualified nurses, with two signatures on prescription chart. Prescription charts included a section for child’s height & weight.

Clinical leads told us there had been a pattern of medicines errors around March to May 2017 on both the ward and NNU in relation to both prescription and administration of medicines to children (none of which had resulted in serious harm). The incident reporting log showed that there had been 80 medicines-related incidents from November 2016 to November 2017 in total, under various sub-categories such as ‘Dose or strength was wrong or unclear’, ‘Medicine not administered’, and ‘Other medication incident’.

Service leads explained the actions they had taken to address this trend, including amending drugs charts to clearly identify the exact times of administration rather than a check box of morning or afternoon time slots; refresher teaching sessions and reflective learning; and ring-fenced protected time for writing prescriptions to reduce the risk of errors. They also ensured that all prescriptions were discussed at handover, which we observed in the two medical handovers we observed. As a result, medicines errors had reduced.

The ward manager for NNU also explained actions they had taken to improve drugs errors, including implementing more time at the cot during handover to go through the drug chart specifically; and conducting a refresher training session to go through prescribing competencies with a sign off once complete.

The risk of medicines incidents was included on the local risk register for children’s services, with appropriate mitigating actions including those outlined above by service leads.

Nurses carrying out drugs rounds on the ward and NNU wore red disposable aprons, which signalled to other people on the ward that they were not to be disturbed, to reduce the risk of errors.

Children’s services had access to clinical pharmacy service from Monday to Friday, with access to an on-call pharmacist out of hours.

There was no nurse prescriber on the ward or NNU; however, nursing staff consistently reported they could get doctors to prescribe medicines promptly, even at night.

Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From October 2016 to September 2017, the trust reported no incidents classified as never events for children’s’ services. (Source: Strategic Executive Information System (STEIS)).
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services, which met the reporting criteria set by NHS England from October 2016 to September 2017. *(Source: Strategic Executive Information System (STEIS)).* This was an improvement (reduction) since our previous inspection.

From November 2016 to November 2017, there were 458 incidents in children’s services reported through the electronic reporting system. The most commonly reported incidents were categorised as ‘implementation & ongoing monitoring/review – other’ (37 incidents); ‘other medication incident’ (29 incidents); ‘lack of suitably trained/skilled staff’ (27); and ‘delay’ (27).

All staff we spoke with could clearly explain how they would raise an incident and give examples of where there had been learning or feedback shared with them from an incident, either raised by themselves or another member of staff.

We asked the clinical leads for the service about any themes or trends in incidents. They identified their main incidents as lower than planned staffing levels; equipment faults; and communications issues (such as extra clinics being booked in outpatients without communicating the updated list to all staff). They were able to give examples of how they were addressing these. For example, regarding the communications incidents, the nurse lead had weekly contact with reception staff and the service manager (responsible for coordinating and booking) to go through the schedule and ensure the resources and rooms were available for appointments the following week. The lead nurse we spoke with in children’s outpatients confirmed they were liaising regularly with the service manager for CYP to improve this trend.

Representatives from children’s services attended a daily trust-wide incident review meeting, which identified any incidents that had occurred in the trust and immediate actions and shared with staff a provisional categorisation of these incidents. This was good practice as it meant the service could benefit from shared learning from incidents that had occurred in other services in the trust.

We reviewed minutes of monthly mortality and morbidity meetings for children’s services from May to November 2017. These minutes included appropriate discussion of mortality and morbidity cases and causes and how things could have been done differently in individual cases, with actions from discussion documented. For example, in a case of neonatal alloimmune thrombocytopenia (NAIT) there were issues identified around poor communication between medical staff in obstetrics and the NNU, and around ensuring all information and medical history is received from the parents. Actions included improved flagging in maternal notes and a discharge letter to be given to the mother to explain the risk for future pregnancies.

Minutes of the monthly patient safety and quality meetings from May to November 2017 showed that mortality and morbidity meeting minutes were also shared in this forum.

At the handover on NNU there was discussion about a patient with a postnatal diagnosis of cystic fibrosis. The consultant suggested this would be a useful case to discuss at the next mortality and morbidity meeting to look at why this had not been picked up before birth, and what could have been done differently.

Not all staff understood the term duty of candour when we asked this specifically. However, they were clearly aware of the need to be open and honest with patients and relatives. 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. However, service leads showed clear understanding of the term duty of candour when asked.
On NNU the ward manager told us about an example of duty of candour where a haemangioma (noncancerous growths of blood vessels) had not been identified which caused the skin to break down. The parents were upset about the missed communication. The ward manager offered the parents a face-to-face meeting to discuss and apologise, which the parents declined, so they sent the parents a letter instead.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from October 2016 to October 2017 for children’s services *(Source: NHS Digital)*. This was an improvement since our last inspection.

**Is the service effective?**

**Evidence-based care and treatment**

There was a comprehensive local audit schedule to monitor performance. Key findings from local audits were documented with actions for improvement.

The service used national guidelines such as those published by the National Institute of Health and Care Excellence (NICE) to inform their own local policies and protocols; for example, the NNU was continuously monitoring their performance and quality against the standards set by NICE Quality Statement 4: neonatal specialist care

The theatre case we observed showed staff working in accordance with best practice and national standards including constant monitoring by the anaesthetist.

The NNU had recently undergone a peer review with positive findings. This was in draft form at the time of inspection, due to be published in February 2018, and was under embargo so we are unable to publish the results. This review assessed key indicators including staffing, compliance with nutrition standards and national guidance, and links with the regional operational delivery network (ODN). The review had not raised any concerns about the unit.

There was an end of life care pathway in place for terminally ill children. This was based on the ‘Together for Short Lives’ national guidance.

Audits were presented to a monthly audit meeting where outcomes and learning was also shared.

The practice development nurses took a lead role in making the clinical guidelines available and accessible to all staff. We saw a folder on the neonatal unit for staff to access that had all evidence based-guidelines organised for staff to access quickly. The guidelines were also available to all staff electronically on the staff intranet.

There was a monthly departmental audit meeting where the results of audits were shared. The feedback was also shared at weekly team huddles, bimonthly forums for band six and seven nurses, and by email newsletter, to ensure all staff were captured in this shared learning.

The NNU had achieved BLISS family friendly accreditation since our previous inspection and had established a named BLISS coordinator to ensure the unit was operating in line with the BLISS baby charter. This is a practical framework for neonatal units to self-assess the quality of family-
centered care they deliver against a set of seven core principles. The service was about to conduct their first self-assessment of compliance with the charter, with a band seven nurse allocated to monitoring each of the seven core principles.

**Nutrition and hydration**

The service had recently appointed a specialist dietician for diabetes.

There was an information board on the ward providing information to parents on breastfeeding and maximising nutritional intake for their baby, including ‘signs that your baby is feeding well’ and how to store milk safely.

We observed a nutritional training session on amino acids for infants, led by a dietician for junior doctors which took place immediately before the morning handover. As part of the training session they were provided with the recent quarterly nutrition update newsletter for paediatric professionals, which discussed different infant food allergies and used case studies to illustrate this.

The NNU was closely following the nutrition standards pathway as part of the regional operational delivery network (ODN).

Malnutrition assessments were undertaken for all children admitted to the service, which included height and weight recording. This was an improvement from the last inspection, where we found height was not included as part of this assessment.

**Pain relief**

There were three types of pain management assessments used on the ward, for the patient, parent and nurse. Within the nursing pain assessment tool, nursing staff would select from means of assessing patients’ pain, based on what was appropriate for the child’s age and behaviour. These consisted of a pictorial faces scale, visual analogue scale, ‘FLACC’ behavioural scale and a physical assessment.

We observed a pain assessment and the chart being completed appropriately using the physical and facial assessment tools. The nurse explained the different pain scales to us and how they selected which was the most appropriate to use. The outcomes of this were recorded and signed and the patient’s pain appeared to be managed.

In the CQC children’s survey 2017, the trust scored 9.1 for children's assessment of whether staff did everything they could to help their pain. The trust scored 8.4 for the same question asked to parents and carers. Both of these were about the same as other trusts.

**Patient outcomes**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”. In the 2015/16 diabetes audit the Princess Alexandra Hospital performed similar to the England average.

The proportion of patients receiving all key care processes annually was 48.3%, which was within the expected range, compared to a national aggregate of 35.5%. The previous year’s score was 46.2%.
The average HbA1c value (adjusted by case-mix) at the trust was 70.8% which was within the expected range, compared to a national aggregate of 68.3%. The previous year’s score was also within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 67, which was slightly worse than the previous year’s median which was 73. *(Source: National Paediatric Diabetes Audit 2015/16).*

The tables below show the percentage of patients (by age group) who were readmitted within two days of discharge, following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table. From March 2016 to February 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (March 2016 to February 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Princess Alexandra Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>1.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Discharges (n)</td>
<td>745</td>
<td></td>
</tr>
<tr>
<td>Readmissions (n)</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

### Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (March 2016 – February 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Princess Alexandra Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>1.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Discharges (n)</td>
<td>1,345</td>
<td></td>
</tr>
<tr>
<td>Readmissions (n)</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

*(Source: Hospital Episode Statistics, provided by CQC Outliers team)*

We requested more up to date data for December 2016 to November 2017 at the time of our inspection. For children under one, there were 22 readmissions, and for children aged 1-17 there were 18 readmissions.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, from April 2016 to March 2017. The trust performed worse than the England average for the percentage of patients aged 1-17 old who had multiple admissions for epilepsy.

### Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (April 2016 to March 2017)

<table>
<thead>
<tr>
<th>Long term</th>
<th>The Princess Alexandra Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Multiple admission rate by condition and age group

<table>
<thead>
<tr>
<th>Condition</th>
<th>Multiple admission rate</th>
<th>At least one admission (n)</th>
<th>Two or more admissions (n)</th>
<th>Multiple admission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>19.2%</td>
</tr>
<tr>
<td>1-17</td>
<td>14.3%</td>
<td>91</td>
<td>13</td>
<td>16.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>27.3%</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>31</td>
<td>*</td>
<td>12.8%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>32.6%</td>
</tr>
<tr>
<td>1-17</td>
<td>45.5%</td>
<td>22</td>
<td>10</td>
<td>26.6%</td>
</tr>
</tbody>
</table>

*Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with **.*

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

In the 2016 National Neonatal Audit Programme (NNAP) the service screened 100% of babies born under 1501g or under 32 weeks gestational age (equating to 46 babies) for Retinopathy of Prematurity (ROP) in accordance with the current NNAP guidelines. This was better than the national average of 98%.

The 2016 NNAP results showed that, of 362 episodes of care, the first documented consultation with parents by a senior member of the neonatal team occurred within 24 hours of admission for 84% of eligible episodes. This was worse than the national average of 90%.

However, by the time of our inspection, the service had received their most recent NNAP results, which showed a significant improvement, now scoring 97% for the first documented consultation indicator.

We could not assess the service for rates of survival at two years compared to similar neonatal units nationally because only one infant out of 16 eligible infants in the NNU during the reporting period had data entered for this metric.

There were 81 babies born under 32 weeks gestational age who were included in the analysis for bronchopulmonary dysplasia (BPD). BPD is a form of chronic lung disease that affects newborns (mostly premature) and infants. It results from damage to the lungs caused by mechanical ventilation and long-term use of oxygen. Of these, 26 were identified as having significant BPD. (Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

### Competent staff

There was an 18-month preceptorship programme for staff to develop skills, competencies and also gain additional experience in any specialist areas of interest. We spoke with a newly qualified nurse who was currently on this programme; they told us they felt well supported and had a named mentor to help them with development. They had a clear structured development programme whereby their competencies were assessed and signed off by both themselves and the mentor.
Induction was comprehensive to ensure staff had the necessary skills and competencies for their work. A health care assistant (HCA) explained they had done a week-long classroom based trust induction, covering topics such as mental health awareness and safeguarding, followed by a healthcare support worker book which they were required to work through with a tutor and sign off. This included topics such as infection prevention and control. There was then a two-week shadowing period during which they had their practical competencies signed off. This was supported by an induction checklist and programme we saw in staff files.

Nursing staff were supported in their revalidation by a dedicated practice development nurse. They were provided throughout the year with any personal feedback from patients and parents and other staff, and were able to use this in their revalidation meetings.

There were examples of staff having opportunities to develop additional skills and competencies and to progress. For example, the ward manager for NNU had recently returned from a secondment to another trust in the region to gain tertiary experience. Another member of staff was currently going through their advanced nurse practitioner course at a London university with support from a consultant at the service.

Staff were not all up to date with yearly appraisals. This was mainly due to low staffing levels in Dolphin ward meaning the manager was having difficulty taking staff away from their clinical work to carry out appraisals. From July 2017 to August 2017, 70% of staff within children’s services at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the graph below:

![Appraisal Rate - CYP graph](image)

(Source: Trust Provider Information Request P46)

The service had recently changed their appraisal system and form to include documentation of the conversation of how the staff member was delivering to the ward and any areas of concern, to make appraisals more constructive and less of a ‘tick box exercise’.

Neonatal ward manager supported through masters and had a mentor for this. They told us their course had been part subsidised by the trust and they had been given study days to achieve this.
Staff were supported and encouraged to increase, improve and maintain skills by working across different areas. For example, one HCA told us they were based on the ward most of the time but also helped out regularly in outpatient clinics.

We reviewed an agency staff folder on Dolphin ward which contained a completed checklist for essential competencies, signed off by the assessor and the member of staff, and certificates of intravenous (IV) competencies.

One ward round each week was a dedicated teaching ward round to help develop and maintain junior doctor competencies and knowledge.

The most recent GMC survey results showed the service was fifth in the region for training and support for junior doctors. This was something the clinical leads highlighted to us as a recent achievement for the service as it was an improvement from the previous survey.

**Multidisciplinary working**

Staff consistently reported effective MDT working internally. MDT meetings on Dolphin ward involved all relevant staff and everyone had an opportunity to contribute. For example, the play specialist attended MDT meetings for children with whom they had a lot of interaction and said that doctors welcomed their input because they might have more of an insight into the wider family and social context of the patient.

Minutes of the NNU clinical leads meeting in November 2017 documented that there was a plan to have weekly MDT meeting with medical, nursing and community teams to discuss and agree the plans of care for the week; and to produce a document to record this and then include it in the medical notes.

An HCA we spoke with said they had the option to attend MDT meetings and were welcomed but had not recently had the opportunity to leave the ward to attend one.

Nursing and medical teams worked well together as one team and we saw positive communication and interactions between them, including in handovers and in theatre, to best support children’s needs. All nursing staff we spoke with said they had good working relationships with doctors and would feel comfortable escalating any concerns directly to the consultant.

In the theatre case we observed, we saw that all members of staff were involved in the discussion, for example in the discussion of allergies and post-operative care.

When referrals were made to other organisations, this was documented in the patient records. We saw an example of this for a child with a complex condition requiring shared care.

In the CQC children’s survey 2017 the trust scored 8.2 out of ten for parents and carers saying the staff caring for their child worked well together. This was about the same as other trusts. *(Source: CQC Children’s Survey, RCPCH)*

However, external MDT working was variable. Clinical leads recognised it as a concern that their access to community services depended on where the patient’s GP was based. They said that for some areas, there were strong external links for home cover and that community staff would attend ward rounds for complex cases, but that other areas were much more limited. Nursing and HCA staff also confirmed that MDT working with external services could sometimes be frustrating and slow.
The two schoolteachers based on the ward told us they had good links with schools if patients were in hospital for a long time and would liaise with the child’s own teachers as needed. For example, on the day of our inspection, a special educational needs coordinator had come from a child’s school and worked alongside the ward teachers to support the child.

### Seven-day services

There was consultant presence to Dolphin ward and the neonatal unit at night and the weekends. The consultant was supported by middle grade and foundation year two doctors during these hours.

Pharmacy support was available 24 hours a day seven days a week to Dolphin ward and the neonatal unit through an on call rota.

Radiology services were available out of hours with the support of an on call radiologist.

There was an on call physiotherapy rota that ensured physiotherapy support was available to Dolphin ward and the neonatal unit if required out of hours. The ward manager for Dolphin ward told us they could always get a physiotherapist to review a patient on the same day if required.

### Health promotion

In the CQC children’s survey 2017 the trust scored nine out of ten for parents and carers saying staff agreed a plan for their child’s care with them (Source: CQC Children’s Survey, RCPCH)

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

There was an up-to-date policy on obtaining consent for treatment on children and staff understood the principles of consent.

Out of five records we reviewed on Dolphin ward, only two had documentation of consent.

Staff were familiar with Gillick competence (a legal principle for assessing a child’s capacity to consent to medical treatment) and Fraser guidelines and how these were applied in practice when caring for children.

However, the service was not carrying out regular consent audits to monitor documentation of consent and identify any areas for improvement.

### Is the service caring?

### Compassionate care

All parents and carers we spoke with were happy with the care of their child. One parent told us their child was regularly admitted to the ward and both the parent and child had formed a good relationship with staff on the ward. Another on NNU said the care was ‘exceptional’ and described one nurse in particular as ‘outstanding’. Another said staff were ‘empathetic’ and ‘friendly’.

All observations of staff interaction with patients and parents or relatives were compassionate and kind. Staff came across as having a patient-focused and empathetic approach; for example one health care assistant (HCA) told us “I love working with children and making parents feel at ease”.

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Staff tailored their communication to best suit the age and needs of each child.

**Emotional support**

Five regular volunteers helped out in children’s services in a non-clinical capacity, to provide support for patients and their families, and respite for parents and carers.

Pastoral care was available to children and their families from the chaplaincy team.

The service could access the trust bereavement nurse for support and reflection.

Parents on the NNU could access support from PETALS, a charity based at another local trust, for emotional and bereavement support if needed.

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

In our observations on the ward of interactions between staff and patients or relatives, staff explained conditions, care plans and progress clearly and listened to and responded to any concerns or questions raised.

Feedback was variable regarding parents being kept well informed. For example, two sets of parents we spoke with on the ward said they were kept well informed about test results and their child’s care plan. Another set of parents on NNU said communication from staff was good.

However, a mother said they did not feel they were always given all the information to understand their child’s progress and that the father was not given the same information. The ward manager on Dolphin ward recognised that ensuring all information was communicated with parents was an area of development for them.

On NNU we spoke with two sets of parents who felt they had been kept well informed about their child’s condition, treatment plan and discharge plan.

We observed two consultations in children’s outpatients and saw that the consultant ensured parents understood what was being discussed. For example, after doing a brief run through of the child’s medical history and ongoing condition, they asked the parents whether that was their understanding or if they wanted to add anything. When carrying out checks on the child, the consultant engaged with them in a friendly and age-appropriate way.

In the CQC children’s survey 2017, the trust scored 6.4 out of ten for children and young people saying that they were involved in decisions about their care and treatment. They scored 8.7 out of ten for children and young people saying staff spoke with them about how they were going to care for them; and that they understood what staff said when speaking with them. They scored 9.7 out of ten for children and young people saying they were able to ask staff questions; and 9.2 out of ten for children and young people saying staff answered their questions. All these scores were about the same as other trusts. *(Source: CQC Children’s Survey, RCPCH)*

The NNU carried out monthly parent feedback surveys. We reviewed these for June – September 2017 and saw they scored highly for ‘involvement in your baby’s care’ (for example, all 16 responses in September said they were encouraged to hold, touch or comfort their baby).

However, the unit scored lower for the question ‘were you given enough information to help you understand your baby’s condition?’ with only nine positive responses out of 16 in the September survey.

**Is the service responsive?**
Service delivery to meet the needs of local people

Patients aged 16 and 17 were treated in adult wards. In the last 12 months, only one child under the age of 16 had been treated on an adult ward and this was for clinical reasons (the child was having a complex chest drain).

In the CQC children’s survey 2017, the trust scored 9.9 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’ The measure is if children spent most of their time of a children’s ward rather than an adult ward. This was about the same as other trusts. (Source: CQC Children’s Survey, RCPCH). This matched what we were told by the ward manager, namely that the service never had to accommodate under 16s in adult wards for capacity reasons. However, 16 and 17 year olds were not offered a choice as to which ward they preferred to be admitted to. The children and young people’s service at this hospital considered 16 and 17 year olds as adults and therefore patients of this age were treated on adult wards regardless of their preference.

The NNU had recently updated their overnight facilities, which included two bedrooms. The parents of a child on NNU said they appreciated that the father was able to stay overnight comfortably. There was also positive feedback from parents about these facilities in the monthly parent survey results we reviewed for June to September 2017. However, the ward manager said it was still an issue that parents did not receive free parking at the trust, although parking was subsidised.

The NNU had also implemented measures to help respond to parental needs. They had recently installed a quiet and private breastfeeding room with reclining breastfeeding chairs separated by a screen. They were also offering sandwiches and light refreshments to parents, in response to feedback. A parent we spoke with said the unit was very responsive to their comments. For example, they had suggested putting a clothes hook in the shower and the service had done this.

In the CQC children’s survey 2017, the trust scored 6.5 out of ten for parents and carers who stayed overnight saying facilities were good. This was about the same as other trusts.

The service had school teachers based on the ward from Monday to Friday during term time to provide children with learning and educational activities for all ages. We spoke with two teachers who showed us examples of this, including arts and crafts activities, books, and maths and literacy work for all ages including those approaching GCSE exams, to help support their educational needs while in hospital. Each morning they would go round the ward and ask children and their parents about any activities or school work they wanted to do, including helping them work through activities children had brought from home.

The teachers offered families the option of doing the work together at the bedside, or the children could work with the teachers in a dedicated classroom on the ward to allow parents respite. We reviewed 15 evaluation forms from parents and children about the service, which were all positive.

The paediatric liaison nurse put together a board displaying information for parents that they might find useful when their child had been discharged. This changed on a monthly basis. At the time of our inspection, the theme was around preventing accidents to children at home.

Meeting people’s individual needs

The service, wherever possible, had one bay allocated to younger children and the other bay to older children/adolescents.
Children’s services did not have a dedicated mental health team, though the local Emotional Wellbeing and Mental Health Service (EWMHS) was accessible for patients admitted to the unit with mental health problems. There was also a seven-day nurse-led crisis team. Staff reported that EWMHS was responsive when they called for advice or to ask for a mental health assessment and that usually someone from the service would attend within one or two hours.

The service had a named link from EWMHS who carried out regular training sessions with ward staff on different techniques of asking questions to children with mental health difficulties and how to support them to help staff respond to these patients’ needs.

There was no dedicated transition team or clear transition pathway for young people who no longer required the children’s services. Guidance from The National Institute of Health and Care Excellence (NICE) recommends that ‘Health and social care service managers in children’s and adults’ services should work together in an integrated way to ensure a smooth and gradual transition for young people (NG43)’. We were concerned that the lack of transition arrangements was not included on the risk register.

Service leads told us this was an area the service was working to improve, for example through improving links with other trusts for transition services. They gave an example of an adolescent patient with spinal muscular atrophy who was still admitted to children’s services due to their complex needs and an individual adolescent care plan had been created for them.

However, we were still concerned that patients aged 16 and 17 were at risk of not having their holistic and individual needs met. For example, we spoke with a 16-year-old patient who had been admitted to an adult medical ward, and who was also experiencing mental health difficulties. They said they had not been visited by children’s services and this had not been offered to them as an option, although staff we spoke with felt there was good joint working between children’s and adult services. It was documented in this patient’s notes that they were not happy on the ward they were on. When we raised this with the ward manager, they said they were aware of the patient’s wishes but there was no other area with capacity where it would be appropriate for this patient to stay as there was no dedicated adolescent unit.

Service leads told us that where required for an adolescent patient, adult and paediatric services would hold a complex care special planning meeting to gain input from both teams; however, this had not happened for the patient we spoke with.

However, the specific transition pathways for children with diabetes or asthma were more clearly established. Children with diabetes attended a joint MDT clinic with the paediatrician and the endocrinologist for the adult service where a joint handover took place, with the support of the diabetes specialist nurse for the adult service. Children with asthma were referred to the adult respiratory physician by the paediatrician and a consultant-to-consultant handover would take place. The transition pathway for children with epilepsy was not in place.

The service had good links with the learning disabilities specialist team to help meet the individual needs of children with learning disabilities. Outpatients’ staff told us they could bleep a member of the team if they needed immediate support with a child and they were very responsive.

There was a sensory room and sensory bathroom on the ward, with a range of light, sound and music therapy and sensory toys, which we were told was particularly beneficial for meeting the needs of oncology patients.

The service had a play specialist, who used distraction techniques to help reduce anxiety in children throughout their stay and whilst receiving treatment, including in the pre-operative stage
before a child went into theatre. This person worked part time and the service was recruiting for another play specialist at the time of our inspection.

Staff could access an interpretation service for children and parents whose first language was not English. This included both phone and face-to-face interpretation options, and staff reported they were quick to respond.

**Access and flow**

Referral to treatment times (RTT) had improved since our previous inspection. RTT refers to the number of patients who start treatment within an 18-week target from when they were referred. Referral to treatment performance from January 2017 to November 2017 for all paediatric medical care ranged between 84.4% and 100% whereas for surgery the referral to treatment performance was lower and ranged between 77.3% and 92%. The total performance for incomplete RTT performance of all paediatric services for this time period averaged around 91%.

Service leads were able to explain measures they had implemented to achieve this, such as increasing telephone clinics in response to patient demand and improving the outpatients ‘choose and book’ system.

Discharge planning began on admission to the ward to ensure timeliness. Discharge plans were documented in four of the five sets of records we reviewed on Dolphin ward and were discussed at the medical handover we observed.

However, the ward was not formally monitoring delayed discharges. Although delayed discharges were not a concern for the service, the lack of documented monitoring meant the service may not be able to clearly identify any increases or trends in delayed discharges and action them accordingly.

The ‘bronze control’ for the division attended daily trust wide bed management meetings to work out capacity and identify patients approaching discharge and provided updates to the ward on this to help maintain efficiency in and flow through the service.

The NNU had recently implemented the ‘HAPPY’ project to improve nurse-led discharges in straightforward and low risk cases, meaning nursing staff did not have to wait for a doctor to
approve the discharge. There had been recent training on timely discharge summaries and the service leads confirmed they did not have concerns about delayed discharges.

An audit of NNU discharges (235 babies) to evaluate the effectiveness of this project was carried out in August 2017. This found that the latest a baby was discharged was 6.30pm (due to last dose of IV antibiotics at 6pm); there were no complaints from parents about their discharge experience; the workload for medical staff was reduced; and there were no issues in getting consultants to sign discharge summaries.

Discharge summaries were clearly documented in nine of the 10 patient records we reviewed on NNU.

In the event that the NNU could not care safely for patients due to high demand for access, babies with the most appropriate clinical circumstances would be transferred to a neighbouring unit as part of the local neonatal network. Babies would be repatriated to the trust when capacity on the unit had reduced. The nurse in charge of the NNU told us there had been no occasions in the last 12 months where they had to close the unit.

In children’s outpatients, there was a board in the waiting room, which kept patients and parents updated as to any delays. This had recently been moved from the corridor area in response to feedback that it would be more visible in the waiting room. This information was being audited, although the service had only started doing this in October 2017 and the information was not yet available for us to review. Staff also kept parents updated verbally if their clinic lists were running behind schedule.

The service had streamlined the rebooking system and ensured better communication between all staff in children’s outpatients. This was an improvement from our previous inspection, where we had concerns that the service lacked capacity to rebook appointments in a timely manner in the event of cancellation.

The children’s outpatients department was monitoring the rates of patients who did not attend (DNA) their appointment. From September to November 2017, there were 149 DNAs. Of these, 58 were discharged and 91 were given another appointment.

The service was currently taking part in a pilot alongside primary care services in the local area to look at ways hospital admissions could be minimised.

**Learning from complaints and concerns**

From August 2016 to July 2017, there were nine complaints about children’s services. The trust took an average of 44 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 180 days of receipt.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

There was evidence of learning from complaints and taking appropriate action. For example, a parent had raised a complaint in August 2017 about their overall experience through maternity and then to the care and treatment in the NNU. The NNU manager and maternity manager held a face-to-face meeting with the parent to discuss their complaint, and the parent then withdrew it.

The service had a feedback scheme using a child-friendly form with a monkey character to encourage children and parents to share both negative and positive feedback. For November 2017, the service received 28 feedback forms, all of which said parents and children were either likely or extremely likely to recommend the service.
The NNU carried out monthly parent surveys to obtain feedback. There was evidence of actions to improve areas where there had been negative feedback, for example, installing curtains in the expressing room to improve privacy for breastfeeding mothers, and launching admission packs to help improve information provided to parents on what to expect.

We did not see any visible information leaflets displayed on Dolphin ward to explain to parents how they could raise a complaint or concern, although there was a booklet at reception about how to feed back about patient experience.

However, two sets of parents we spoke with on the NNU said they knew how to raise a complaint if they felt the need.

Is the service well-led?

Leadership

The children and young people’s service was led by a clinical lead, an associate director of nursing and head of midwifery, and an associate director of operations. These senior leaders were supported by the head of children’s nursing and services and the paediatric matron who in turn supported the Dolphin ward and neonatal unit managers.

The leadership structure of the service was established and all staff were clear about who had responsibility. At ward level, both Dolphin ward and the neonatal unit had ward managers. Ward managers received leadership from the paediatric matron.

The paediatric matron reported to the head of children’s nursing, who in turn reported to the associate director of nursing and head of midwifery. Medical leadership came from the clinical lead for paediatrics who was a practicing consultant at the trust.

Both nursing and medical staff consistently reported they had good relationships with service leads and described managers as approachable and supportive. For example, one nurse said “nursing support is fantastic”.

Staff reported that the senior leadership team were visible and regularly spent time within the service. The trust chief executive officer (CEO) ran a weekly meeting, which all staff were welcome to attend, and encouraged all staff to raise any questions or concerns directly to them.

Vision and strategy

Although there was no strategy specific to CYP services, the service was represented in the overarching five year plan for Family and Women’s Services. This plan was a working document to be continually reviewed and updated in response to actions, changes in the health economy and completed activity. The service had planned an away day for CYP services in February 2018 to focus on producing an action plan; completing their workforce review; and add further detail to their five year plan.

The service was represented in the trust-wide clinical quality service strategy. Their vision and strategy included developing a paediatric assessment unit (PAU) as part of a wider clinical network for paediatrics, to help sustainability and flow within the service. Staff we spoke with were aware of these plans.
The service was also focusing on staffing levels, retaining existing staff and recruiting to meet planned staffing levels on Dolphin ward. It was included in the vision that they aimed to support the development and progress of staff, for example in training to become nurse specialists.

Culture

There was a positive, team-based culture across the service. For example, one outpatients nurse said they felt valued and encouraged to raise ideas and pursue their areas of interest. An agency nurse on Dolphin ward told us they felt included as part of the team and enjoyed working in the service. A receptionist told us they felt included as part of the team; they had previously worked in the service for 15 years and had recently returned after a two-year break.

Staff consistently reported they felt empowered and confident to raise concerns if they felt the need, and were supported by their managers to do this. They could access the trust whistleblowing policy and procedure if they needed to.

The culture had improved from our previous inspection, where we had concerns about the poor culture and lack of accountability on Dolphin ward and the neonatal unit around daily checks of emergency trolleys, drug fridge temperature and controlled drugs.

The clinical leads were proud of the positive change in culture since our previous inspection. Following concerns raised about culture in the NNU in the Picker survey carried out in September 2017, the ward manager had carried out monthly surveys with involvement from the quality team, and had held ‘values and culture’ meetings with staff to identify and address concerns. This had resulted in more positive feedback about culture in the last 12 months. This was reflected by staff on NNU who told us there was a positive and supportive culture and they enjoyed working there.

Governance

Clinical governance in relation to staff appraisals and training, clinical indicators, infection control, audit and incidents and complaints for the service took place at the monthly patient safety and quality meetings.

Monthly divisional clinical governance meetings took place and were attended by senior staff from both medical and nursing teams as well as clinical audit and governance leads.

A clinical governance newsletter was sent out electronically on a monthly basis to all staff in the service. This shared learning from complaints and incidents for the service with a no blame approach.

Management of risk, issues and performance

We asked the clinical leads for the service about their main risks. They told us these were staffing levels, particularly for Dolphin ward; discharge summaries not being completed fully and consistently within 72 hours; and the ophthalmology retinopathy (ROP) outpatient follow up clinic currently being held in NNU due to lack of dedicated area, which increased the risk of infection and security on the unit. They were able to explain actions they were taking to mitigate these. For example, to address the discharge summaries risk, they were holding meetings with medical staff to discuss reasons for this and offering overtime when needed to ensure the summaries were completed adequately.
The risks we were told about and had seen on inspection were, in the main, reflected on the risk register, for example low training compliance rates and staff not receiving yearly appraisals. Risk awareness and mitigation had improved since the last inspection.

There were 16 open risks on the local risk register at the time of our inspection, which each had an appropriate person allocated to overseeing it and appropriate actions in place to mitigate them as far as possible. They also had target risk levels to help drive improvement, and target dates for addressing the risks.

For example, in relation to the ROP risk, which was red/amber/green (RAG) rated as red, actions included booking extra staff from NNU on clinic days to support ophthalmology, circulating a weekly list of clinic attendees so that staff know who to expect, for security reasons.

Risks on the register were discussed and reviewed at monthly patient safety and quality (PSQ) meetings at divisional level and then escalated to the trust wide monthly risk review meeting for risks that had increased.

However, we were concerned that the lack of transition arrangements and pathways within the service, to meet the needs of adolescent patients, was not included on the risk register.

The top three local risks were displayed on an information board on Dolphin ward and NNU to ensure everyone remained aware of them.

### Information management

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via paper patient records and the staff intranet.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

Babies admitted to NNU had data collected and stored securely (with parental consent and in line with the Data Protection Act 1998) on Badgernet. Badgernet is a database used in all neonatal units in the region. The data collected supports the ongoing development of neonatal care.

### Engagement

Staff we spoke with felt engaged with their work and with the development of children’s services. They were encouraged to suggest and help implement developments. For example, a nursery nurse had suggested the ‘HAPPY’ project to improve nurse-led discharges in straightforward and low risk cases, meaning nursing staff did not have to wait for a doctor to approve the discharge on NNU.

The service had an ‘employee of the month’ scheme to recognise staff commitment, care and achievement in children’s services. Photos of the current recognised staff member were displayed on an information board in Dolphin ward alongside a note about why they had been selected. Staff knew about this scheme and were able to use it as evidence of good performance in appraisals and revalidation.

There were opportunities for staff to undergo NHS leadership courses. The ward manager for the NNU had been supported through the leadership programme and won awards for commitment to her work.
The NNU had recently tried to encourage more parental engagement with the service by inviting parents whose babies had previously been on the unit to attend staff study days to share their experience. They said this was well received by both parents and staff.

**Learning, continuous improvement and innovation**

Service leads demonstrated a commitment to continuous improvement and development. For example, the NNU had recently received BLISS accreditation and undergone a peer review to identify areas for improvement and areas of strength.

The service leads also used their links with tertiary services in the region and London to identify areas where they could improve, for example discussing with a local trust about better performance in some of the NNAP indicators.

Staff we spoke with said they were encouraged to make suggestions for improvement or change. For example, staff in NNU regularly did presentations on study days to share information about audits they had recently conducted or additional training or learning they had done, such as a newborn behavioural training course recently attended by a nurse.
End of life care

Facts and data about this service

The trust provides end of life care at The Princess Alexandra Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,099 deaths from August 2016 to July 2017.
(Source: Hospital Episode Statistics)

Princess Alexandra Hospital does not have a dedicated ward for end of life care. However, the trust opened Gibberd Ward, a 27-bedded ward in September 2017, which provides care for patients with dementia and those requiring end of life care. Patients admitted to this ward must have documented agreed ceilings of treatment, a Treatment Escalation Plan, (TEP) and they must have an indefinite do not attempt cardiopulmonary resuscitation (DNACPR) order in place.

The specialist palliative care team (SPCT), which consists of specialist consultants and nurses, provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of life.

The SPCT received 692 referrals from December 2016 to November 2017, 59% of these being for patients with a diagnosis of cancer. The SPCT was available six days a week, from 9am to 5pm, Monday to Friday. Outside these hours, advice was provided by the local hospice via telephone or in person if required.

The service was previously inspected in June 2016 and was rated overall as inadequate.

We completed a short notice inspection of the end of life care service from 5 to 7 December 2017 and an unannounced visit on the 17 December. We visited 12 areas, including accident and emergency, medical wards, surgical wards, mortuary, bereavement suit and hospital chapel. We spoke with one patient and five relatives. We spoke with 40 members of staff including medical director, non-executive director with responsibility for end of life care, medical and nursing staff, allied health professionals, the SPCT, portering, mortuary and chaplaincy staff. We reviewed 11 patient care records, 37 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and information including policies, procedures and audits. We observed board rounds, SPCT MDT meeting and attended the End of Life Improvement Programme Steering Group’s meeting.

Is the service safe?

Mandatory training

All members of the specialist palliative care team (SPCT) took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as basic life support, conflict resolution, dementia awareness, fire safety, infection control, health and safety, learning disability awareness, information governance, moving and handling and safeguarding adults and children. Data from November 2017 showed the SPCT were 100% compliant with all the mandatory training modules apart from basic life support, where one member of staff’s training for basic life support had expired. However, they had been booked to undertake the
training in December 2017.

The mortuary and bereavement services completed mandatory and statutory training. Data provided from December 2017 showed the team were 100% compliant in all but one mandatory training module. Two members of the mortuary team had to complete the Prevent/Health Wrap module.

End of life care awareness training was given as part of the mandatory trust induction programme, where the SPCT delivered a three-hour awareness session during the staff induction-training program. The mortuary and bereavement team and the chaplaincy team also delivered training as part of the trust’s induction programme.

The team on Gibberd ward had prioritised the training topics to ensure staff were competent to care for the admitted patient group. The trust set a target of 95% compliance with mandatory training. On Gibberd Ward completion rates by nursing staff was varied. There was 100% compliance in conflict resolution, dementia awareness, equality, diversity and human rights, learning disabilities awareness, Prevent, safeguarding adults and children. However the training rates for basic life support (40%), blood training (60%), infection control (60%), moving and handling (60%), fire awareness (80%), health and safety (80%) and information governance (80%), were all below the trust target.

Medical and dental staff on Gibberd ward were part of the Medicine Health Care group. There was a very low mandatory training completion rate amongst the medical staff on Gibberd ward. Of the four medical staff identified as working on Gibberd ward, there was an average training completion rate of 27%. One member of the medical team had not completed any mandatory training.

**Safeguarding**

All staff we spoke with understood their role concerning keeping patients safe and reporting any potential safeguarding issues.

Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.

Staff told us if they had any concerns they would speak to the trust’s safeguarding lead or their manager, and knew where to access the trusts’ safeguarding policy on the intranet. We found no concerns during the inspection in relation to safeguarding patients in receipt of end of life care.

At our last inspection in July 2016, we noted that safeguarding had been removed from the ‘COMPASSION’ tool used to assess patients on a shift by shift basis and had been replaced by spirituality. During this inspection, we noted a safeguarding risk assessment had been added to the ‘COMPASSION’ tool. The care plan for the anticipated last days of life also included a check for safeguarding assessment. This meant the trust had taken appropriate steps to ensure safeguarding risks were appropriately considered.
Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training. Overall, this core service had a 100% completion rate for all safeguarding training, which exceeded the trust target of 95%.

A breakdown of compliance for safeguarding courses from July 2017 for nursing/midwifery staff in end of life care is shown below:

<table>
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<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
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<tr>
<td>Safeguarding Adults level 2</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children level 2</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing & midwifery staff exceeded the trust target of 95% for both Safeguarding Adults Level 2 and Safeguarding Children Level 2 reaching a 100% completion rate.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

All members of the SPCT had completed the trust’s infection control training level 1 and 2. Of the staff in the mortuary and bereavement team 100% had completed the trust’s infection control training Levels 1 to 3.

The mortuary manager explained the process for decontamination following post mortem, and the process for decontamination following the autopsy of a patient with an infectious disease. The process used in both cases was appropriate. There were no post mortem during our inspection and we therefore did not see the decontamination process.
The trust had up-to-date infectious post-mortem cases and mortuary cleaning and decontamination policies. These were appropriate and in line with the Health and Safety Executive safe working and prevention of infection in the mortuary and post-mortem room guidance.

The mortuary team had a daily and monthly cleaning schedule in place for all areas of the mortuary. We reviewed the cleaning records from October to December 2017 and found all the daily and monthly cleaning checks were completed accordingly.

Personal protective equipment (PPE), such as aprons and gloves, was readily available throughout the mortuary setting for use by staff and visitors. This was in line with the trust’s standard infection, prevention and control policy.

Gibberd ward was visibly clean and uncluttered. “I am clean” stickers were visible on equipment to signify it was clean and ready for use. Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE) and to the ‘bare below the elbow’ guidance to help prevent the spread of infection.

All clinical waste bins had the correct coloured bin liners. We noted three sharps bins within the ward were assembled and the attached label completed correctly. These containers were, within the recommended fill level, minimising the risk of needle stick injuries.

Environment and equipment

Although end of life care patients received care across the hospital, Gibberd ward, a purpose-built 27-bedded ward opened in September 2017, provided care for patients with Dementia and those requiring end of life care.

During our previous inspection in June 2016, we raised concerns about the condition of the fridge doors in the mortuary. As part of this inspection, the mortuary was re-inspected to establish if improvements had been undertaken. We found that the mortuary had undergone a refurbishment programme, which included the main body cold stores chiller and deep freeze units, door fascia and floor covering of the post mortem room. All the areas of concern around the mortuary environment identified at our inspection in June 2016 had been following our inspection with major refurbishment work completed in January 2017.

A further concern we raised at our June 2016 inspection related to an additional 20 fridge spaces, which were housed in a mobile unit outside the mortuary. Access was restricted, the door, was locked and CCTV was in use. However, the mobile unit was overlooked by offices and wards. This meant the mobile unit was visible to staff and members of the public who may be looking out of these windows. During this inspection, we saw that a screen had been erected to ensure privacy from members of the public and hospital staff. In addition, a wheel lock had been applied to immobilise the mobile unit to mitigate the risk of the unit being moved. The trust continued to monitor the unit by CCTV.

The trust had its Human Tissue Authority (HTA) compliance inspection in December 2016 and the mortuary was found suitable to be licenced by the HTA subject to the corrective and preventative actions implemented to meet the shortfalls identified during the HTA inspection. We reviewed the action plan and all actions had been completed and closed.

The cold store units and the air-handling unit in the mortuary had a quarterly planned preventive maintenance (PPM) schedule in place. However, there was no evidence of a PPM schedule for the mortuary equipment, such as trolleys and taps to show they were being tested and regularly.
maintained. The mortuary manager told us that they would report any faults on equipment to the trust estates department for repairs.

Fridge temperatures in the mortuary were consistently recorded on a computer system. An alarm sounded should the fridge temperatures drop below the required temperature. Faults on the fridges were alerted through the hospital switchboard to the mortuary and maintenance teams, who were available 24 hours a day to respond to any problems.

Staff were able to access syringe drivers that met national safety standards to provide anticipatory medicines to patients at the end of their life. A contract was in place to ensure syringe drivers were calibrated and serviced. We reviewed a selection of syringe drivers on Gibberd ward and the planned preventive maintenance (PPM) schedule which were all tested and in date.

Assessing and responding to patient risk

The trust used a version of the National Early Warning Score system (NEWS). We saw evidence of the use of the National Early Warning Score (NEWS) in 11 sets of the patients’ notes we reviewed and all of the early warning indicators were regularly checked and assessed. The National Early Warning Score system is a way of standardising the identification and assessment of acute illnesses and the deteriorating patient.

The trust had introduced a tool to support clinicians to discuss, plan and document individualised ceilings of care for patients in their anticipated last year and days of life by introducing the Treatment Escalation Plans (TEPs). This ensured patients at the end of their life had a clearly documented ceilings of treatment in place. This was an improvement from the last inspection in 2016, where there was no evidence of escalation plans or documented ceilings of care, which had posed a risk of inappropriate escalation of patients or continuity of treatment, which was likely to be unsuccessful.

We reviewed 11 sets of nursing and medical care records. Ceilings of care were documented in nine out of the 11 records. Ceilings of care or treatment are often agreed between healthcare teams, and where possible, the patient or family so that if deterioration in their condition occurs suddenly, all involved in the care of that patient know how to proceed. A patient’s ceiling of care could include not escalating to intensive care or not performing cardiopulmonary resuscitation.

Patients had a personalised care plan for anticipated last days of life when it was recognised that they were expected to die within days or hours. This was to ensure care in the last days of life was tailored to the patient’s needs and those important to them. Of the 11 care records we reviewed, three were on the anticipated last days of life care plan. Whilst one was fully completed. The other two were not so well completed with noticeable gaps in both records.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience. Staffing of the specialist palliative care team (SPCT) was in line with the national guidance (the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds). The trust’s SPCT consisted of three whole time equivalent (WTE) clinical nurse specialists (CNS) in palliative care, one WTE ceilings of treatment nurse adviser, one 0.4 WTE palliative care practice development clinical nurse specialist and one WTE administrative and clerical support.
The SPCT were supported by palliative and end of life care ward champions, whose roles included raising awareness of EOLC processes, and educating and supporting more junior staff. At the time of our inspection, there were no vacancies in the specialist end of life care nursing establishment.

Gibberd ward was a 27 bedded ward, which had been opened in September 2017. The ward provided care for patients with dementia and for those requiring end of life care. Patients admitted to Gibberd ward had to have documented agreed ceilings of treatment (Treatment Escalation Plan – TEP) and an indefinite Do not attempt cardiopulmonary Resuscitation (DNACPR) order in place. This ensured the most appropriate patients were transferred to this ward.

Nurse staffing on Gibberd ward was made up of one WTE band seven nurse, 2.4 WTE band 6 and 17.3 WTE band 5. However, there was a high vacancy rate with 1.5 WTE band 6 and 14.2 WTE band 5. The ward matron told us that staff shortages were being mitigated by using agency staff that had worked at the trust on a regular basis.

The mortuary and bereavement service consisted of a service manager, 2 WTE anatomical pathology technicians (APTs), and 2 WTE bereavement advisers. At the time of our inspection there was a vacancy for 1 WTE mortuary support worker.

Both the service manager and the staff in the mortuary and bereavement service told us that the current staffing establishment was not sufficient for the amount and level of service the team provided.

**Sickness rates**

From April 2016 to May 2017, the trust reported an average sickness rate of 0.9% in end of life care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Medical staffing**

The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care states there should be a minimum of one consultant per 250 beds. There were three consultants within the specialist palliative care team, which together equalled 1.4 WTE. This was an improvement from the last inspection in 2016.

The trust now had a substantive palliative care consultant in post since November 2017. Two palliative care consultants provided the 0.4 WTE hours between them, as part of a service level agreement with a local hospice.

The National Institute for Health and Care Excellence (NICE) guidelines for end of life care in adults (QS13) recommends between 1.56 and 2.0 WTE palliative care consultants per population of 250,000. The Princess Alexandra Hospital served a population of approximately 350,000, meaning around 1.4 WTE consultants were required and therefore the trust meets the QS13 guidance.
Out of hours, consultant support was available through the hospital switchboard from the palliative medicine consultant on call.

**Records**

Patients approaching the end of their life had an anticipated last days of life care plan in place. The aim of the care plan was to ensure that dying patients and their families received the best level of care and support during the last days of life. However of the three care plans we reviewed only one was completed appropriately and the other two contained information that was sparse and there were gaps in both records, including assessment of spiritual care and discussion around preferred place of care/death (PPC/D).

The trust had introduced a tool to support clinicians to discuss, plan and document individualised ceilings of treatment and care for patients in their anticipated last days of life by introducing the Treatment Escalation Plans (TEP). However in all the wards we visited a draft version of the document was being used. We escalated this to the senior members of the SPCT who told us that these were produced while the TEP was being piloted. They assured us that the draft forms would be removed from use from all clinical areas. However on our unannounced inspection on 17 December 2017 we established the draft forms had not been removed and the trust was still using the draft TEP forms. We escalated this to the chief executive officer of the trust who assured us that immediate action would be taken.

Nursing staff used a comfort rounding tool to assess patients in the last days and hours of life. The comfort rounding tool is a prompt for nursing staff to undertake and monitor a patient for mouth care, comfort, hydration, safety and pain and to ensure patients are repositioned for comfort.

The SPCT reviewed the Individualised care plan for the anticipated last days of life record to audit compliance with documentation and recording of ceilings of care. Results from April 2017 showed 38% (three out of eight) of the records reviewed had a care plan completed. The review also indicated that staff were not always documenting comfort rounding, with 50% of the records meeting the review standard. The SPCT recommendation following this review was to have targeted training. There was no data to show outcomes of the actions taken.

The SPCT made detailed entries within each patient’s multidisciplinary team records. Documentation was clear and concise and considered all aspects of patient care. SPCT documentation followed the hospitals ‘COMPASSION’ acronym for assessing and documenting care. The ‘COMPASSION’ acronym stood for: communication, observations, medications, pain, activities of daily living, skin, safeguarding, spirituality, invasive devices, oral care and nutrition.

The hospital had a sticker system in place to indicate when a patient had been seen by the SPCT. Further documentation was then made to support the outcome of the review. The trust also used stickers within patient notes to highlight a patient’s preferred place of death (PPD) or care (PPC).

The mortuary had a robust system for checking the deceased into and out of the mortuary. On admission to the mortuary, in addition to hospital wrist bands with the deceased name, date of birth and NHS number on, an individual mortuary number was assigned to each patient. The individual number was attached using pre-printed stickers to the deceased wrist band, property
and within the mortuary register. This was used as an additional check prior to any procedures or discharge from the mortuary. We reviewed the mortuary records, including body release forms and booking in procedure, which were accurate and matched the mortuary occupancy at the time of our inspection.

In the areas we visited, we saw that patient records were securely and safely stored which protected confidentiality.

**Medicines**

The trust opened Gibberd ward in September 2017 to provide care for patients with dementia and those requiring end of life care. Medicines on Gibberd ward were stored securely in locked cupboards in a locked room that was only accessible by authorised staff.

Controlled drugs were secured in a lockable wall mounted cupboard that was only accessible by authorised staff. The controlled drugs cupboard on Gibberd ward was locked securely and all stock levels were accurately documented. The cupboard was locked when not in use and keys held by one authorised member of staff.

On Gibberd ward, records showed that medicines requiring refrigeration were stored within the recommended temperature range, with daily monitoring of temperatures of the medication fridge taking place. This included details of the acceptable temperature ranges and actions required should the temperature fall out of this range. Records reviewed were mostly completed correctly from 1 October to 5 December 2017. In total there were four days where fridge temperature checks had not been recorded. However, the monitoring of ambient room temperatures in areas where medications were stored was not recorded.

Patients receiving end of life care medicines were prescribed anticipatory medicines (medications that are prescribed for use on an ‘as required’ basis) to manage common symptoms that can occur at the end of life. These were prescribed in advance to promptly manage any change in the patient’s pain or other symptoms. We reviewed nine medication administration records and found that allergies were clearly recorded on prescription chart, and regular medicines prescribed included the dose, route, frequency and were signed by the prescriber.

During our inspection, we found that staff on Gibberd ward did not routinely sign and date the bottles of liquid medication once it had been opened. Although a bottle of liquid medication has an expiry date, once opened, the expiry date is shortened. We found an out of date liquid medication that had expired due to there being no date of opening on the bottle. The medication had been administered seven times since it had expired. We raised this as a concern with the matron for Gibberd ward and appropriate action was taken.

**Incidents**

There were systems and processes in place to report incidents and staff told us they were encouraged to do so. Incidents were reported through the trust’s electronic reporting system.

Ward staff we spoke with knew how to report incidents using the trusts electronic reporting system. They were able to give examples of the type of incidents, which required escalation and reporting. The SPCT told us of an incident that was recently reported around the misconception of administering sub-cutaneous fluid to a patient who was at the end of their life. As a result of this incident a patient information leaflet was re-written to address the misconception.
Processes were in place to investigate incidents, including the undertaking of a root cause analysis and systems for identifying learning points.

We reviewed four of the most recent incidents relating to the end of life care services across the hospital. All four incidents were recorded as moderate harm. The information provided showed details of the incident, actions taken and lessons learned.

The trust held daily serious incident group (SIG) meetings where all new incidents were discussed. We attended a SIG meeting where an incident relating to a patient who was at the end of their life was discussed. Appropriate decisions were made in relation to grading the incident and the actions that were taken forward from the meeting.

Any incident relating to end of life care was also referred to the End of Life Improvement Programme Steering Group for discussion and sharing. The group met monthly and incidents were a standing agenda item.

Staff in all roles supporting palliative and end of life care services had an understanding of the duty of candour requirement. The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to the person.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2016 to September 2017, the trust reported no incidents classified as never events within end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in end of life care, which met the reporting criteria set by NHS England from October 2016 to September 2017.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The trust had an End of Life strategy (2017 - 2020) which referred to various national standards and guidance; such as Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020; Leadership Alliance for the Care of Dying People (2014) and National Institute for Health and Care Excellence (NICE) (2017).Quality standard - Care of dying adults in the last days of life/ end of life care for adults (QS144).

The Individualised care plan for the anticipated last days of life recognised the priorities for care according to the Leadership Alliance for the Care of Dying People: A national framework for local
action 2015-2020. The Leadership Alliance for the Care of Dying People promotes a consistent approach to end of life care through five key principles.

The care plan was used across the trust in all adult wards. The individualised care plan for the anticipated last days of life document guided clinicians through a series of prompts to discuss the patient’s personal and clinical needs, preferences, and the amount of intervention required. It guided clinicians to consider the emotional, psychological and spiritual support needed.

We reviewed three individualised care plan records, one of which showed details of a conversation held with a patient and their family. This included recognition of dying, symptom control, and assessment of nutrition and hydration needs. The other two care plans had a number of sections that were left blank.

The trust undertook audits across a variety of areas, including do not attempt cardio pulmonary resuscitation (DNACPR) completion and Treatment Escalation Plans (TEPs) within all adult areas, Individualised care plan for the anticipated last days of life, SPCT response time to referrals and preferred place of death (PPD)

We reviewed the audits of PPD, DNACPR completion and Treatment Escalation Plan (TEP), which were monthly audits. Audit of in-patient anticipatory End of Life (EoL) prescribing and individualised care plan for the anticipated last days of life where a one off audits without any re-audit date included.

The aim of the audit plan was to monitor the effectiveness of the service. The SPCT also told us of other planned audits that were to be included in the audit plan. These included: Individualised care plan for the anticipated last days of life; comfort round and patient and family information following implementation of new documents; observational audit of end of life patients across the trust including bed occupancy on Gibberd ward; rationale for end of life patients being cared for on a specific ward and a snapshot of ward multidisciplinary teams (MDTs) to identify current end of life patients. We asked when these audits were going to be undertaken but the trust did not give a date for these planned audits.

**Nutrition and hydration**

The trust used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of malnutrition. Nutrition and hydration were part of the ‘COMPASSION’ documentation tool and the last days of life care plan as areas for consideration. Patients were encouraged to eat and drink as and when they are able to and for as long as they are able to in their last days of life.

Patients and family members we spoke with during our inspection were happy with the food on offer at the trust. They told us staff gave them option wherever possible.

Throughout our inspection, we saw patients had drinks within easy reach and were routinely offered fluids throughout the day.

We saw evidence in patients’ nursing and medical records that nutrition and hydration needs were being met. The Individualised care plan for the anticipated last days of life included a comprehensive list of nutrition and hydration considerations. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing difficulties and respecting the dying person’s choice to eat and drink. Staff we spoke with showed a good understanding of the importance of nutrition and hydration.
Приемы лечения боли

Приемы лечения боли были установлены для управления болью у пациентов в последние дни жизни. Эти руководства были доступны в виде схем на отделениях, которые мы проверяли. Они также были доступны через внутреннюю сеть компании, что обеспечивало легкий доступ к ним персоналу.

Боль оценивалась как часть ежечасного комфорта, а также в качестве компонентов ежедневных обходов. Мы видели доказательства оценки боли и предпринимаемые соответствующие действия. Оценка боли была частью инструмента оценки «COMPASSION» используемого персоналом, а также была частью плана ухода в последние дни жизни.

Антисипативное назначение (ликарских средств, которые назначаются на основе потребностей, чтобы управлять общей симптоматикой, которая может возникнуть при достижении конца жизни) следовало руководству NICE по управлению симптомами.

Мы рассмотрели девять медицинских карт пациентов, у которых были TEPs. Пять из девяти пациентов имели антисипативные лекарственные препараты.

Мы говорили с четырьмя родственниками, которые рассказали, что их близкие получали хорошую боль и их боль была под контролем.

Персонал всех отделений, которые мы проверяли, сказал, что консультанты по специализированной паллиативной помощи (SPCT) могли предложить рекомендации по наиболее эффективным и правильным методам и определенным этапам ухода при завершении жизни, включая лечение боли и управление тошнотой и рвотой.

Где это было необходимо, пациентам предоставляли синдромные дозы, которые обеспечивали равномерное поступление лекарственных средств по 24 часа. На всех отделениях, которые мы посещали, все квалифицированные медсестры были обучены по использованию синдромных доз и управлению их управлением.

Результаты пациента

Завершение жизни в больнице 2016 компания участвовала в двух из пяти медицинских показателей, которые были превышены по сравнению с единым средним уровнем. Компания получила 78% за пациента, у которого в последний этап ухода был документирован факт, что пациент умирал в ближайшие часы или дни.

(источник: Royal College of Physicians)

В последнем отчете по завершению жизни в больнице, опубликованном в марте 2016 года компанией, была оценена возможность пациента разговаривать о своих проблемах (84% совпадает с национальным уровнем) и документировано наличие в последний день жизни оценки всех потребностей в виде индивидуальной медицинской программы (67% против национального уровня 66%)

Действовал план действий, чтобы решить проблемы, которые компания не могла решить. План действий включался в план улучшения жизни в компании, что обеспечивало постоянный контроль за действиями и выполнением работы компании.

Мы рассмотрели 11 медицинских карт пациентов, которые были близки к концу их жизни. Все записано, что пациенты были умирающими или близко к концу жизни. Это было установлено как часть индивидуального плана ухода для предполагаемых последних дней жизни или в медицинской карте.
The trust participated in local audits to measure patient outcomes. The audit assessed the individualised care plan for the anticipated last days of life compliance with documentation and recording of ceilings of care. Information provided by the trust was from April 2017. The result showed 88% were fully compliant with recording the ceilings of treatment in the medical notes, using the COMPASSION tool to record nursing notes, record preferred place of death (PPD) and DNACPR completion and included in notes. However, only 38% had a fully completed care plan in place and 50% of the notes audit the end of life care comfort round was being used. Actions from the audit results were noted, however there was no re-audit date included within the actions and therefore we could not be assured that continued review and improvements were being made.

Referrals to the Specialist Palliative Care Team
Between December 2016 and November 2017, 692 referrals were made to the Specialist Palliative Care Team (SPCT), of these referrals 59% were cancer related and 41% were non-cancer related.

Competent staff
All new staff were provided with three hours of palliative and end of life care training during their mandatory corporate induction. The SPCT played an active role in developing the training program with input from the Chaplaincy and bereavement team.

Porters that transported deceased patients to the mortuary had a set of competencies, which were signed off by the mortuary manager. These competencies included: the booking in process, infection control and the safe movement of deceased patients.

Palliative and end of life care champions were in place on every ward. End of life champions attended additional training sessions, which included shadow sessions at a local hospice or with the hospital SPCT. This enabled them to complete competencies. This was an improvement from our last inspection in June 2016, where end of life care champions were not in place across the trust.

As part of the trust’s end of life care strategy, an education strategy had been put in place to enable collaborative working with other palliative care providers to develop education programmes across all settings. We saw an extract from the draft Palliative and End of Life Care Strategy for the Hertfordshire and West Essex Sustainability and Transformation Plan. The plans incorporated common core competences including communication skills, assessment and care planning, symptom management, comfort and well-being, and advance care planning.

Appraisal rates
From August 2016 to August 2017 100% of staff within end of life care at the trust had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Reporting Unit/Ward</th>
<th>Number of staff required</th>
<th>Number of staff received appraisal</th>
<th>Appraisal %</th>
</tr>
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<tbody>
<tr>
<td>Specialist Palliative Care Team</td>
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<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>PAH Mortuary</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>
Multidisciplinary working

We saw evidence of multidisciplinary working on Gibberd ward for a patient in receipt of palliative care and who required a fast track discharge. Multiple professionals had contributed to the discharge process including the patients' medical team, discharge coordinators and the SPCT. Multidisciplinary team (MDT) meetings were held weekly and attended by the hospital SPCT nurses, consultants, allied health care professionals and members of a local voluntary sector that provided carer support. This was an improvement from inspection in June 2016 where the SPCT nurses and consultant only attended the MDT meeting. During this inspection, we observed a regular SPCT MDT meeting. Staff from each designation contributed to the needs of each patient and their family/carer.

Staff we spoke with were aware of how to contact the SPCT and were positive about the input and care delivered by the SPCT.

Referrals to the SPCT came from multiple professionals, including nursing, medical and allied health professionals. Nursing staff felt confident to refer to the SPCT and to ask for advice and support.

Ward staff and managers told us the specialist palliative care team attended the ward when referrals were made formally and less formally for advice and support when requested to do so. The specialist palliative care team routinely visited the wards.

All the wards we inspected had a dedicated discharge coordinator that attended daily handover sessions.

The trust had a system in place to highlight patients who were at the end of their lives. Patients in receipt of end of life care were identified by a ‘golden hand’ magnet on each ward’s white board. This helped members of the MDT to identify these patients at the board rounds.

Seven-day services

The SPCT provided a Monday to Saturday 9am to 5pm service. Staff could access a palliative care consultant out of hours through switchboard. The SPCT told us they achieved 97% response to referral in 24 hours and 50% referral seen the same day.

The SPCT told us a further review to increase staffing to support a seven day service was put on hold until the next financial year and further review of funding will be put forward as business planning for 2018-19. We saw this was documented with the service risk register January 2018.

The hospital chaplaincy service had chaplains of various denominations that could be contacted to provide holistic support for patients and families 24-hours a day, seven days a week.

The bereavement team provided a service between 8.30am to 4.30pm Monday to Friday. Mortuary staff were on site during the day, Monday to Friday 8am to 4.30pm. Outside normal working hours, mortuary staff had a 24-hour emergency on-call system and could be contacted through the hospital’s Switchboard.

Porters had access to the mortuary 24 hours a day, seven days a week, which enabled prompt transfers of deceased patients from clinical areas to the mortuary.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as mandatory training. Staff we spoke with were able to describe the process they would follow should someone be found to not have capacity to agree to treatment or be able to make decisions in relation to their care.

MCA and DoLS guidance was available on the trust’s intranet along with other associated documents such as the trust’s consent policy, dementia policy and safeguarding adults at risk policy.

Throughout our inspection, we reviewed 37 do not attempt cardio pulmonary resuscitation (DNACPR) forms. Of the 37 DNACPR records reviewed, 18 (49%) were completed in line with Resuscitation Council UK guidelines.

Of the 37 DNACPR forms we reviewed, 23 had documented that the patient did not have mental capacity. This meant these patients should have had a mental capacity assessment completed. However only three (13%) of the patients had a clearly documented MCA assessment. The other 11 records (48%) only had the check box in the treatment escalation plan (TEP) for mental capacity assessment ticked, with only two having a detailed rational for the best interest decision completed. The remaining nine records did not have any evidence of mental capacity assessment or best interest decision documented.

The trust has provided copies of their MCA policy and DoLS policy. The trust’s MCA policy stated that a full MCA assessment must be carried out when a person’s capacity is in doubt and a serious medical decision needs to be made, for example any decision not to continue active treatment.

We were therefore not assured that the principles of the MCA or the trust’s MCA policy were consistently followed for people who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation.

The trust had adopted the National Resuscitation Council DNACPR form to be used across the trust, with some amendments to include a quality review by a senior nurse. The new form had been in use since April 2017.

The trust-wide DNACPR audit report dated October 2017 looked at DNACPR orders. The aim of the audit was to ascertain compliance with the trust’s DNACPR policy. The results of the audit showed that out of 68 DNACPR records audited in October 2017, 99% had a clearly defined reason why CPR was not considered appropriate. This was a significant improvement from 42% in February 2017. The audit data also showed that there was a significant improvement from 25% (February 2017) to 82% (October 2017) of forms clearly identifying that the decision has been discussed with those involved. However, there was inconsistent result for MCA two assessments being undertaken, for example with 56%being compliant in October 2017 compared to 78% in September 2017. The trust had identified this as a risk and told us that it was a focus of the quality improvement work undertaken alongside the introduction of the treatment escalation plan (TEP)

We saw no patients at the end of life or receiving palliative care that had an active DoLS in place at the time of the inspection. Staff we spoke with had a good understanding of DoLS and were able to provide rationales for not applying for a DoLS when asked.
Mental Capacity Act and Deprivation of Liberty training completion

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) training was delivered as part of the trust mandatory safeguarding training. Data provided showed that 100% of staff within the specialist palliative care team had completed this training.

Is the service caring?

Compassionate care

Throughout our inspection, we observed patients treated with compassion, dignity and respect. Medical and nursing staff we spoke to were aware of the importance of treating patients and their visitors in a sensitive manner. All staff we spoke with had a genuine desire to want to provide the best possible care to patients at the end of their life.

We saw that end of life patients, wherever possible were cared for by ward staff in side rooms to protect the privacy and dignity of the dying patient and their families.

The trust had recently opened Gibberd ward, which was a dedicated environment to care for patients living with dementia, and those in receipt of palliative and end of life care.

Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring patients and their families were cared for with compassion and respect, both before and after death.

During our inspection, the hospital chaplain told us of a recent wedding they had conducted which the ward staff on Locke ward and SPCT helped to organise to fulfil the wishes of a dying patient. The SPCT told us of how a local business donated items including confetti and silk button holes for a wedding box.

The hospital Chaplin told us about a baptism of a baby on the neonatal intensive care unit (NICU) was conducted in September 2017 and a memorial service was held for a member of staff in October.

The hospital chaplain told us that the bereavement team sent invites out to the next of kin of patients who had died within the trust, offering them the opportunity to attend one of the memorial services that were conducted. Each year, the Chaplaincy also hosted a service to support those who had experienced the loss of a baby.

We spoke with two patients and five relatives during our inspection. The patients and relatives were consistently complementary about staff attitude and engagement.

We heard from ward staff of two occasions where they had facilitated so that end of life patients could be visited by their dogs.
We saw a letter from a relative who was cared for at John Snow ward. The family member stated that “…staff were compassionate and caring both to mum and to all the family.”

Porters and mortuary staff told us the bodies of deceased patients were handled in a compassionate way.

**Emotional support**

The specialist palliative care team (SPCT), ward staff and chaplain provided emotional support for patients and their relatives. Staff told us they would give patients and their relatives as much time as they needed to talk about their thoughts and feelings.

The trust bereavement survey conducted in November 2017 showed that of the 32 respondents, 15 (45%) said that they were given the chance to talk to someone about any worries/ anxiety/ fears they had. Of those who responded 40% said they were not given a chance and 15% didn’t respond to the question.

The bereavement team understood the importance of emotional support. Members of the bereavement team were qualified bereavement counsellors and offered support to the families who had lost loved ones. We heard of examples of how the mortuary and bereavement team ensured that people could take the time they needed and didn’t rush people so they could say goodbye to their relatives and ask any questions they may have of the bereavement team.

There was a guidance document available through the bereavement team for what to expect at the next stages once a person has died, this provided information and support to people to inform them of what to expect and how the bereavement team signpost them to relevant information and support.

The trust was in the process of recruiting ‘butterfly’ volunteers. These are people who are trained to sit with dying patients and support their relatives. During our inspection, two butterfly volunteers had already started visiting Gibberd ward and offering support to patients and their families.

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

We reviewed 12 sets of medical and nursing care records, which showed some discussions between clinicians and patients and those close to them. In some cases, the views of the family were detailed, while others stated that the family member understood the plan.

A family on Gibberd ward told us they had been kept informed throughout the care process and were aware of the next stages. The family were very happy with the level of information provided and the discussions that had taken place.

The trust conducted a bereavement survey, to determine the care provided in the last few days of life and experience of that time. The most recent survey was conducted in July 2017 and of the 32 respondents, 27 (85%) said that they were given the opportunity to talk with any of the doctors involved in relative’s care.

The bereavement survey result also showed that of the 32 respondents, 26 (80%) felt involved in decisions about their relative’s care.

Relatives confirmed there was open visiting. Local leaders told us they would offer relatives to stay over if they wished to do so and would organise foldaway beds if the patient was in a side room.

Relatives confirmed staff supported them to stay overnight as comfortably as possible and we saw arrangements were in place to facilitate this.
Is the service responsive?

Service delivery to meet the needs of local people

As there was no locality wide register to record patients preferred place of death in Hertfordshire or Essex, the trust was unable to feed into a locality wide register. However this was captured on the individualised care plan for the anticipated last days of life and was monitored by the specialist palliative care team (SPCT).

Data submitted by the trust showed that in October 2017, 92% (against a trust target of 80%) of patients that were on the fast track database had a recorded preferred place of death (PPD), which was an improvement from 90% in September 2017 and 65% in August 2017.

Data submitted by the trust also showed that between August 2017 and October 2017 100% of patients on the fast track database had a recorded preferred place of care (PPC). Between April 2017 and October 2017, on average 54.6% of patients achieved their first or second choice of PPC. The discharge team told us the main reason for delays in discharge was due to delays in sourcing care in the community and this impacted on some patients not achieving their preferred place of care or death.

When patients were recognised by their lead clinician as being at end of life, patients were recorded on the ward whiteboards and a “golden hand” magnet was put next to the patients’ bed number. All patients at the end of their life were also captured on Safer Staffing daily reports and on ward handover sheet. The SPCT could also access the trust’s electronic system to refresh an end of life care list on a daily basis, ensuring a rapid response from the SPCT to support the ward nurses, patient and families as needed.

Data from August to October 2017 showed that 100% of referrals to the team where responded to within 48 hours. For the month of September and October 100% of referrals to the team where responded to within 24 hours and 97% for August 2017. The data also showed that 97% of patients were seen within 24 hours in August 2017 and this had improved to 98% and 99% for September and October respectively.

Patients in receipt of palliative or end of life care were cared for across all clinical areas throughout the hospital; however, the trust opened Gibberd ward in September 2017, which was designed to care for patients with dementia and patients requiring end of life or palliative care. Patients were allocated side rooms wherever possible.

Patients from the main hospital wards could not be admitted to Gibberd ward overnight, as transport was required to take the patients. We observed that a patient died on a trolley in the emergency department during the night as there were no beds available in the hospital. Although beds were available on Gibberd ward, there was no transport to transfer the patient.

There were no visiting restrictions for family or friends of those receiving end of life care.

The wards we inspected provided portable beds for those relatives wishing to stay with their loved ones in a side room.

Carers and family members of patients at the end of life had access to free car parking and food and drink within clinical areas.

Meeting people’s individual needs

The chaplaincy gave examples of when wedding ceremonies, baptisms and special services had been organised for patients and staff within the hospital.
The Chapel was a multi-faith space and was open 24 hours a day, seven days a week for people of any faith or none. Prayer mats for people with a Muslim faith was available. We saw copies of the Holy Bible and Koran and multi-faith books.

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.

On the wards we inspected, a symbol of a ‘golden hand’ was placed on the patient’s door or curtain, to make all staff aware that the patient was receiving end of life care. This was also communicated during ward handovers.

The SPCT provided a ‘comfort pack’ to families and relatives with who may have to stay at short notice as their loved one was dying.

The trust had a system in place to access telephone and face to face translation and interpreter services.

A viewing room in the mortuary provided families or friends a private quiet space should they wish to spend time with the deceased.

We did not see any specific facilities within the mortuary to accommodate religious needs in terms of end of life rituals, for example allowing a family to wash the deceased. The mortuary staff told us it could be possible to facilitate specific needs if they were told prior to the family arriving. Alternative arrangements could be made and or facilities brought into the viewing room to accommodate specific requirements.

The bereavement service told us that they would facilitate rapid access to death certificates and the release of the deceased back to their families. The accessibility of the bereavement services allowed families to observe religious traditions, for example being buried within a certain length of time, as the process was more streamlined.

**Access and flow**

There were 692 referrals to the Specialist Palliative Care Team (SPCT) between December 2016 and November 2017. Of the 192 referrals received between August and October 2017, the SPCT were able to visit and assess on average 98% of patients within 24 hours of referral, against a target of 100%. Preferred place of care and preferred place of death was identified on the Individualised care plan for the anticipated last days of life document.

The SPCT monitored whether end of life patients who were referred to the service achieved their preferred place of care/death (PPC/D) on discharged. Data from August to October 2017 showed this was significantly increasing, with 65% in August, 90% in September and 92% in October achieving their PPC/D against a trust target of 80%.

The fast track discharge of patients in the last days and weeks of life (last two to four weeks of life) was coordinated by the integrated discharge team. All the wards we visited had a discharged coordinator that attended the board rounds to identify any patients that require fast track discharge and would coordinate with the integrated discharge team.

The trust had set a three-day target for the average length of stay for patients who had funding agreed to time patient is discharged. Data provided showed, from February to October 2017 the average length of stay was 5.8 days.

The trust also monitored the average length of stay for referral to fast track assessment (Average Zero days against a target of one) and also assessment to funding decision (average one day
against the target of one). For both these key performance indicators the trust has been consistently meeting or exceeding the stated target since April 2017.

Senior members of the SPCT and the integrated discharge team told us that the trust had worked across the health economy to make the fast track process for both CCG areas the same decreasing the delays for discharged that was previously caused.

Senior staff told us the fast track discharge process worked well. Ward staff told us that they had not had patients delayed from being discharged to their preferred place of death due to the process but due to families changing the minds and lack of availability of community palliative beds.

There were systems and processes in place to monitor the rapid discharge process which was an improvement from the last inspection.

**Learning from complaints and concerns**

Staff reported receiving very few complaints in relation to EOLC. From August to October 2017 the trust had received three complaints about end of life care. We reviewed the investigation into the complaints. All three complaints had aspects of lack of communication between ward staff and the next of kin. We saw the action plan for the lessons learnt and the actions taken to address the complaints.

Complaints were discussed as a standing agenda item in the ward huddle, governance meeting, trust end of life improvement programme steering group monthly meeting. In addition any lessons learnt from complaints were shared in the SPCT newsletter. The SPCT also attended the trust’s healthcare group meeting where complaints are discussed and lessons shared as part of performance review. We were able to see from the meeting minutes recent complaints concerning end of life care discussed and key learning points shared at the meetings.

Ward staff gave an example where lessons learnt were shared following a complaint, regarding communicating with the families of a patient. The complaint was discussed at the end of life care steering group and the findings were disseminated to all staff concerned.

**Summary of complaints**

From August 2016 to July 2017 there were no complaints about end of life care.

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*

**Is the service well-led?**

**Leadership**

There was effective and professional leadership that encouraged and supported the delivery of person centred care and we saw this throughout the services we inspected, the specialist palliative care team (SPCT), the mortuary service, chaplaincy and the bereavement service.

End of life care was led at an executive level by the Chief medical Officer and supported by a non-executive director (NED).

The trust end of life improvement programme steering group was chaired by the associate clinical director quality first.
The trust had a substantive palliative and end of life care consultant who had started in post in November 2017. This was an improvement from the last inspection where there was a lack of medical palliative care leadership at the trust.

The palliative care consultant and palliative care nurses demonstrated good leadership in the clinical areas, and staff we spoke with on the wards recognised who they were.

Staff we spoke with throughout the trust were aware of the SPCT. Staff also reported about the good working relationship with them and the support and training they provided.

Vision and strategy

The trust had an end of life care strategy (2017-2020) in place. The strategy built on the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2012, outlined the goals and aims and recognised that end of life care was everyone’s business. This was an improvement from the last inspection where the trust did not have a vision or strategy for end of life and palliative care services.

The strategy for end of life care had been set around the trust’s values, standards and behaviours. The implementation of the strategy was being monitored through the trust’s end of life care steering group.

The trust was also part of the Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Palliative and End of Life Care Strategy Group, a system wide locality strategy for end of life care.

The Hertfordshire and West Essex STP Palliative and End of Life Care Strategy Group had representations from across health and social care organisations, in Hertfordshire and West Essex that were involved in providing care and support for people in the last years of their life.

At a local level, the SPCT were clear about the strategy and vision for palliative and end of life care service. The end of life care champions attended meetings and EOLC training and they shared relevant information at ward level.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was recognition of the importance of end of life care across all staff groups throughout the hospital. Staff were engaged with the trust and proud of the care and treatment provided for patients at the end of their life.

Staff we spoke with showed a commitment to delivering good quality end of life care. Although they all mentioned the issue with lack of staffing within the wards, staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff about the level of support they received from the SPCT.

Mortuary and bereavement staff showed a strong team ethic and a structured working relationship. The mortuary and bereavement teams demonstrated a willingness to improve the care and experience of both the deceased and their relatives.
Governance

There was a clear governance structure for end of life care.

Palliative and end of life care services operated throughout the trust. Specialist palliative and end of life care service sat under the Cancer, cardiology & clinical services. A quarterly end of life care report was presented to the quality and safety committee and a yearly report to the trust board.

The trust monitored the end of life service through the end of life steering group, which met monthly and was chaired by the associate clinical director. This group was supported through weekly meetings of the multidisciplinary team, who discussed patients at the end of their life, delays in discharges and current plans of care.

The SPCT produced a monthly quality assurance dashboard that monitored performance of the service.

During our inspection we found the trust’s treatment escalation plan (TEP) forms, used to document individualised ceilings of care for patients in their anticipated last year and days of life where still a draft version. We escalated this to the senior members of the SPCT who told us that these were produced while the TEP was being piloted. They assured us that the draft forms would be removed from use from all clinical areas. However, on the follow up unannounced inspection on 17 December 2017 the trust was still using the draft TEP forms. Therefore, we were not assured that there was a robust system in place to monitor version control of forms used in clinical areas.

The specialist palliative care team produces a quarterly newsletter, which gives highlights of end of life care in the trust and shares the learning from incidents and complaints. The newsletter also raises awareness of resources and new policies.

Management of risk, issues and performance

The trust end of life care risk register was submitted as part of the divisional risk register. We reviewed the divisions risk register entries and found that these was up-to-date and that the risks captured reflected the risks staff on inspection had told us about. For example, risks listed on the register included absence of a seven day specialist palliative care service, absence of an electronic palliative care co-ordination systems (EPaCCS) and accurately recording data of SPCT activity to ensure team can report on activity and achievement. There was evidence that the risks were being reviewed and updated regularly. The risks that were on the register had control measures in place and a review date.

The trust achieved six of the eight organisational indicators in the End of Life Care Audit: Dying in Hospital 2016. The two indicators that they did not achieve were access to specialist palliative care for at least 9am to 5pm, seven days a week and the trust having an end of life care facilitator.

We reviewed the action plan for the audit and senior members of the SPCT told us that currently the service provides a Monday to Saturday 9am to 5pm service and have achieved on average 98% response to referral in 24 hours and over 50% referral seen the same day. A further review to increase staffing to go to seven-day service was going to be put forward part of business planning for 2018-19.

We reviewed the October 2017 palliative and end of life care quality dashboard. The service monitored their performance by measuring against the CQC’s five domains and red, amber, green (RAG) rating their performance. The areas that were measured and RAG rated included; referral rates, preferred place of care/date, incidents, complaints, discharge to patient’s preferred place of care/death and EOLC training. A number of the indicators were rated green or amber. However
there were areas that were rated red, including the percentage of patients referred to SPCT with recorded Preferred Place of Death (PPD), compliance with DNACPR audit element (which included identification of who the decision had been discussed with) and compliance to the fast track discharge trust target.

**Information Management**

Specialist Palliative Care Team received referrals via an electronic referral system and could also be contacted via telephone.

Staff across the trust could access information from the intranet, such as policies and national guidance. In the wards that we visited, staff were able to demonstrate that they could easily access information on palliative/ end of life care from the intranet, and also from an end of life care folder kept in the ward. The folder contained information relating to end of life care, including the referral process for the SPCT. Staff in all clinical areas knew of the folder and where to it.

**Engagement**

The trust conducted a bereavement survey in November 2017. A total of 32 surveys were completed. The survey highlighted some good practices including; being given the opportunity to talk with any of the doctors involved in loved one’s care (85% responded yes), being involved in decisions about their relative’s care (95% responded yes), wishes of loved ones’ being respected by those caring for them (85% responded yes) and that their loved one was comfortable when they died (80% responded yes).

The survey also highlighted areas for improvement. These areas included; discussion about where their loved ones wanted to be cared for in their last days (45% responded yes), religious and cultural beliefs taken into consideration by those caring for their oved ones (55% responded yes) and being given the chance to talk to someone about any worries/ anxiety/ fears (45% responded yes).

During the inspection we attended the end of life steering group where the results from the bereavement survey was presented at and action plan was taken forward to conduct the next survey in the Spring of 2018.

Patient representatives were invited to the end of life care steering group. Minutes from the end of life steering group from June to November 2017 showed patient representation at the group.

All the wards we visited had end of life care champions that assisted with training and information sharing.

**Learning, continuous improvement and innovation**

The SPCT in October 2017 won ‘the most inspiring trust’ award in as part of the end of life collaborative organised by NHS improvement. The team was recognised for the work they did to create an integrated service that ensures minimum stress for patients when they were at their most vulnerable.

The trust was part of the Hertfordshire and West Essex Sustainability and Transformation Plan (STP) Palliative and End of Life Care Strategy Group, which was working on a system wide locality strategy for end of life care, to care and support people in the last years of their life.
The trust had a system in place to highlight patients who were at the end of their lives. These patients had a ‘golden hand’ magnet next to their bed number on the ward white board for ease of identification and discussed at board rounds. In addition, the SPCT were able to refresh an end of life care list daily from the whiteboard reports with names and where patients were, ensuring a rapid response from SPCT to support the ward nurses, patient and families as needed.