East and North Hertfordshire NHS Trust

Evidence appendix

Lister Hospital
Coreys Mill Ln, 
Stevenage 
SG1 4AB

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Date of inspection visit:
20 to 22 March and 23 to 25 April 2018

Date of publication:
17 July 2018

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

Background to the trust

East and North Hertfordshire NHS Trust was established in 2000 and is a large acute trust in Hertfordshire. It provides secondary care services for a population of around 600,000 in East and North Hertfordshire as well as parts of South Bedfordshire. The trust also provides tertiary cancer services for a population of approximately 2,000,000 in Hertfordshire, Bedfordshire, North-West London and parts of the Thames Valley. It is not a foundation trust.

The trust has four main locations; Lister Hospital, Queen Elizabeth II Hospital (QEII), Hertford County Hospital and Mount Vernon Cancer Centre, as well as community children’s and young people’s service and two renal units based in Bedford and Harlow.
The breakdown of the four main sites can be seen below:

<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>Lister Hospital</td>
<td>Coreys Mill Lane, Stevenage, Hertfordshire, SG1 4AB</td>
<td>Renal medicine, plastic surgery and urology</td>
<td>East and North Herts</td>
</tr>
<tr>
<td>Hertford County</td>
<td>North Road, Hertford, Hertfordshire, SG14 1LP</td>
<td>The hospital provides outpatient, diagnostic and therapy services.</td>
<td>East and North Herts</td>
</tr>
<tr>
<td>Queen Elizabeth II Hospital</td>
<td>Howlands, Welwyn Garden City, Hertfordshire, AL7 4HQ</td>
<td>Outpatient, diagnostic and antenatal</td>
<td>East and North Herts</td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>Mount Vernon hospital, Rickmansworth Road, Northwood, Middlesex, HA6 2RN</td>
<td>Specialist radiotherapy and chemotherapy</td>
<td>Herts, Beds, North West London and upper Thames valley</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites)

The trust concluded its “Our Changing Hospital” programme in 2015, having invested £150 million to enable the consolidation of inpatient and complex services on the Lister Hospital site, delivering a reduction from two to one District General Hospitals. Mount Vernon Cancer Centre operates out of facilities leased from a different NHS foundation trust.

We inspected some core services at Lister Hospital, QEII Hospital and Mount Vernon Cancer Centre as part of this inspection. We did not inspect Hertford County Hospital, children’s community services or the two dialysis units.

**Facts and data about the trust**

There are approximately 647 general and acute beds, 48 maternity beds and 30 critical care beds across the trust.

The trust is structured under five clinical divisions:

- Women’s and children’s
- Medical
- Surgical
- Cancer
- Clinical support services.
A triumvirate, comprised of a divisional director, a divisional chair and a head of nursing, led each clinical division. Therapy services and outpatient pharmacy services were provided by different organisations.

As of August 2017, the trust employed 4,922 staff, including 695 doctors, 1,339 nursing staff and 2,888 other staff. As of October 2017, all staff turnover was 12.7%, against a trust target of 10%.

The health of people in Hertfordshire is generally better when compared to the England average. Hertfordshire is one of the 20% least deprived counties in England. However, about 13% (29,300) of children live in low-income families. Life expectancy for both men and women is similar to the England average.

Information from the last Census in 2011 found that ethnic minorities living in Hertfordshire was about the same as the England average; with just over 80% of people living in the county classed as white British compared to almost 80% in the whole of England. However, statistics show that black and minority ethnic groups in Hertfordshire have risen from 11.2% in 2001 to around to 19.2% in 2011.

**Patient numbers**

Trust activity for September 2016 to August 2017:

- 149,932 A&E attendances (+2% change compared to the same time 2015/16)
- 89,175 inpatient admissions (+6% compared to the same time 2015/16)
- 862,487 outpatient appointments (+1% compared to the same time 2015/16)
- 1,658 deaths (+2% compared to the same time 2015/16)
- 5,332 births (-3% compared to the same time 2015/16)
- 260,634 bed days (0% compared to the same time 2015/16)
- 1,279 critical care discharges (+2% compared to the same time 2015/16)

**Financial Position**

We inspected the trust's financial governance particularly its financial leadership, management and governance arrangements in conjunction with NHSI Improvements (NHSI).

In 2015/16 on an income of £384.4 million the trust had a deficit (shortfall) of £16.7m. For the financial year 2016/2017, the trust's income was £411.4 m. There was a reported deficit of £29.5m, an increase of £12.8m from the previous financial year.
## Financial metrics

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Income (£000s)</td>
<td>£384.7</td>
<td>£411.4</td>
<td>£419.1</td>
<td>£429.1</td>
</tr>
<tr>
<td>Full Costs (£000s)</td>
<td>£401.4</td>
<td>£440.9</td>
<td>£442.5</td>
<td>£432.4</td>
</tr>
<tr>
<td>Surplus (deficit) (£000s)</td>
<td>(£16.7)</td>
<td>(£29.5)</td>
<td>(£23.4)</td>
<td>(£3.3)</td>
</tr>
<tr>
<td>Budget (£000s)</td>
<td>(£8.0)</td>
<td>(£8.7)</td>
<td>(£7.7)</td>
<td>(£3.3)</td>
</tr>
</tbody>
</table>

### What people who use the trust's services say

In the CQC Inpatient Survey 2016 (published May 2017), the trust generally performed about the same as other trusts for most of the questions. Responses were received from 459 patients at East and North Hertfordshire NHS Trust. The trust scored worse than other trusts in the following:

- Whether patients knew which nurse was in charge of their care.
- Whether patients received enough emotional support from hospital staff.
- Whether discharge from hospital was delayed.
- Whether patients were told about medication side effects.
- Whether hospital staff considered their family and home situation when planning their discharge.

To write this well-led report, and rate the organisation, we interviewed the members of the board, including the executive team, and a range of senior staff across the hospital. We spoke with some of the non-executive directors as part of a focus group. 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, action plans, meeting minutes, papers to the board, investigations, and feedback from patients, local people and stakeholders.

### Is this organisation well-led?

#### Leadership

The stability of the senior leadership team had significantly improved, with only one interim executive post at the time of our inspection. The leadership team understood the challenges to quality and sustainability faced by the trust. They were able to identify the actions needed to address them and recognised the significant volume of work required to improve quality of care at the trust, and ensure it was sustained. However, many of the planned projects were at an early stage.
Since our last inspection in October 2015, there had been significant changes to the trust board. The trust board generally had the appropriate range of skills, knowledge and experience. Its members had an appropriate level of operational and financial experience and expertise across both non-executive directors (NEDs) and executives. For example, the finance and performance committee (FPC) and the audit committee were chaired by NEDs with considerable financial skills, which they gained from previous roles in the private sector. Both NEDs joined the trust during 2017.

The trust board consisted of:

- The chair (appointed in April 2016)
- Chief executive officer (CEO) (appointed in November 2002)
- Medical director (appointed in December 2017)
- Director of nursing and patient experience (appointed in January 2018)
- Director of strategy (appointed in February 2017)
- Chief operating officer (COO) (interim, appointed in September 2017)
- Chief people officer (appointed in January 2014)
- Director of finance (appointed in October 2016)
- Five NEDs

There was not a clear, formal induction programme for all trust board members. NEDs had received a structured induction, which was overseen by the trust’s chair and company secretary. However, the induction programme for new executive directors was not well developed and was arranged on an ad hoc basis, dependent on the preferences of the new executive member. Sustainability of improvements was an ongoing focus for the newly formed leadership team. Sufficient board time was spent reviewing the trust’s finances. In addition, there was also a separate monthly FPC.

Discussions with frontline staff in focus groups, which we held before the core service inspection, drew mostly positive comments from staff about leadership. Most staff also reported that senior executive leaders were visible and approachable. However, some staff at Mount Vernon Cancer Centre (MVCC) and the Queen Elizabeth II (QEII) hospital told us they rarely saw senior leaders as they were mostly based at Lister hospital.

Our interviews held with the trust leadership team demonstrated a level of awareness of the priorities and challenges facing the trust and how these were being addressed. Executive leaders spoke with insight about these challenges, which included learning from never events and serious incidents, recruitment and retention of staff. Both the newly appointed director of nursing and medical director were clear about prioritising issues surrounding patient safety and although new in post were already having a very positive impact. The executive leaders considered the greatest challenge to the trust to be their financial position and more latterly, the implementation of a new electronic patient administration and record system. Although the leadership team could articulate the challenges, they were yet to be fully documented on the corporate risk register, which was under review at the time of our inspection.
A new accountability framework was introduced for 2018/19, which described how the organisation monitored and supported the delivery of its key organisational objectives and targets. It set out how divisions would be held accountable and how performance would be managed during 2018/19. One of the aims of the framework was to repair the damage caused to the relationships between the divisions and the finance team in 2017/18 by creating a new culture of earned autonomy for the divisions.

The availability and accuracy of the trust’s operational information had been materially affected since the implementation of the new electronic patient record computer system in September 2017, replacing an antiquated system which did not give all the information that was required. Staff across the trust, from executives through to clinical and administration staff, told us that this implementation had impacted on everyone. One executive described it as being ‘all consuming.’ It had been acknowledged that there had been insufficient planning and a slow response to problems when the system had been implemented. This had impacted considerably on the trust’s operational and financial position. Not only because the trust incurred unplanned stabilisation costs but also because it had impacted on the trust’s ability to effectively schedule patient procedures and appointments.

The board believed that once these issues had been resolved the new system would enable more accurate reporting, better activity and resource planning and implement the clinical efficiencies identified.

Infection prevention and control fell under the leadership of the director of nursing. The infection prevention and control team reported directly to the director of nursing and this proved an effective method for communicating relevant issues at board level.

The trust had a leadership, management and coaching development pathway for aspiring, new and experienced leaders form all staff groups. This recognised there were three main areas essential to staff development, which were statutory and mandatory training, professional and technical development and leadership, management and coaching development. The trust supported staff to complete the aspiring director programme and the aspiring chief executive programme. A number of previous executive directors had gone on to secure chief executive appointments. The trust was part to regional networks and the accelerated director development programme, which was a cross partner initiative hosted and lead by the trust.

Fit and Proper Persons

Trusts are required to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 19 of the Health and Social Care act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are of good character and have the right qualifications and experience to carry out this important role. We found that not all the employment files were compliant with the Fit and Proper Persons Requirement.

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive and non-executive directors, in line with the FPPR requirement. Although there was a clearly defined policy in place, dated November 2017, to govern this
process, we found that not all the employment files were compliant with the regulation. For example, three of the six NED files (including the chair) were missing photographic identification, and four of the six NED files were missing references. The NEDs had been appointed by NHS Improvement (NHSI) who undertook their recruitment checks. However, the trust was responsible for requesting copies of any checks or references completed by NHSI to assure them that the NEDs were of good character.

The trust had developed a fit and proper person’s checklist for the executive directors. The checklist covered the requirements of the regulation, including a disclosure and barring check, financial checks and references. This was situated at the front of each file to demonstrate that the information required was present. In addition, an annual declaration was made by NEDS and executive directors to confirm that there was nothing that would affect their fitness as a director of the trust. Of the 14 personnel files we reviewed, two were missing these declaration forms.

Board Members
Of the executive board members at the trust, there was no representation from the black and minority ethnic (BME) population and 42.9% were female.

Of the non-executive board members, there were no BME and 33.3% were female. The board did not reflect the diversity of the local population.

<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>42.9%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

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

Vision and strategy

The trust’s short-term vision was to implement actions to improve safety across the trust. This included full implementation of the new electronic patient record computer system. Work was in progress to develop a long-term vision and strategy. Due to the early development of the strategies and lack of staff consultation, staff were unable to explain how their role would contribute to achieving the strategies.

The trust had developed a five-year strategic plan for 2015-2020, underpinned by the trust’s vision and values. The strategy detailed three aims:

- Delivering our promises on value and quality
- New ways of caring
- Develop the Mount Vernon Cancer Centre
These were all underpinned by nine strategic objectives. These all had key priorities to deliver success to ensure the objectives were met. However, the work of the board had been dominated by delivering the financial plan and the disruption caused by the new electronic patient record computer system.

**The trust acknowledged its overall strategy for 2018/19 was a limited refresh of its previous strategy and was embarking on a process to agree a new long-term strategy. The new strategy would include a long-term financial strategy and financial recovery plan.** This process was being led by a NED, who was the chair of the FPC and had considerable experience in strategy development.

Staff had been knowledgeable about the ‘our changing hospitals’ programme which saw the reconfiguration of services across the trust and the changes to QEII Hospital. However, the future strategy was less visible to staff as there was not big changes to the use of buildings and as there had been previously and there was more focus on clinical strategies and links to the ‘Getting It Right First Time’ programme to improve the quality of care by bringing efficiencies and improvements.

The trust’s vision was “to be amongst the best in all that we do; including patient experience, clinical outcomes, patient safety and financial sustainability.”

The trust’s current values were based on the acronym PIVOT:

- We put our **patients** first.
- We strive for excellence and continuous **improvement**.
- We **value** everybody.
- We are **open** and honest.
- We work as a **team**.

The values had been in place since just before our last inspection in October 2015, and had been determined through a small selection of staff. Most staff we spoke with during our inspection were aware of the trust values. The values appeared well embedded. Staff could describe and direct us to posters on display across the hospitals.

The trust was part of the Hertfordshire and West Essex sustainability and transformation partnerships (STP). The STP governance arrangements had recently been refreshed and strengthened and the trust was represented at the partnership board, at the delivery board and at work stream level.

The trust was aware that its vision needed reviewing to reflect the new leadership at the trust and changes in the NHS system, such as the Five Year Forward View and the commencement of STPs. We saw that early discussions about this had taken place at the November 2017 board meeting, with the suggestion to amend the vision to “improve, innovate and inspire”.

The chief pharmacist had a broad awareness of the challenges to the quality and sustainability of the pharmacy service. The trust’s three-year medicines optimisation strategy (2015-2017) and business plan had been completed in 2017. The trust was in the process of producing a new
strategy during our inspection, which would be based on the hospital pharmacy transformation plan. The chief pharmacist told us that the key priorities for the new strategy would be to reduce delayed critical medicine administration with the aim to improve patient outcomes, ensure medicines were stored safely, and implement electronic prescribing across the trust.

Culture

Leaders across the trust were promoting a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, there were mixed views from staff on how they felt supported, respected and valued.

The leadership team understood the importance of a positive culture and placed significant emphasis on this. However, some senior staff were dissatisfied with how they had been communicated with, particularly around finances. They understood that there needed to be financial control to ensure the trust was financially viable, however, they felt their autonomy had been removed and changes had been delivered as instructions rather than two-way discussions. The financial team were working to repair these relationships; each division had a financial business partner. The aim was that this would create a common purpose to achieve high quality patient care, collective achievement of shared goals through determining the vision, priorities and signature behaviours for the organisation, whilst not compromising safety or quality. Whilst this was welcomed by some staff; some perceived the action of challenging staff behaviours as bullying.

We met with different groups of staff including consultants, nurses, allied health professionals, clinical and directorate leads and support staff. We also held focus groups, which were attended by all staff groups, where we spoke with approximately 350 staff across the trust. Most staff were universally proud of the care they were delivering to patients. However, all staff negatively described the impact that financial controls had on the trust and staff. For example, they informed us that some recruitment and external training had been prevented, and some of the senior staff were unable to adequately support junior staff because of the focus on finance. This was especially prevalent at the Lister site.

Bullying and harassment was incorporated into the trust's policy for dignity and respect. This was ratified in September 2014 and was due for review in December 2016. We requested to see a copy of the updated policy; however, we did not receive this.

There had been previous culture issues at the trust in some areas, including at Mount Vernon Cancer Centre (MVCC). However, the trust had commissioned a review of behaviours at MVCC. The centre had also appointed a new management team at MVCC, who were in the process of realigning these negative behaviours to reflect the trust’s values.

Freedom to Speak Up Guardian

We were not assured the trust had a systematic approach to measure the effectiveness of its speaking up policies, procedures, and culture.

The Freedom to Speak Up review by Sir Robert Francis into whistleblowing in the NHS in 2015, concluded that there was a serious issue in the NHS that required urgent attention if staff were to
play their full part in maintaining safe and effective services for patients. Several recommendations were made to deliver a more consistent approach to whistleblowing across the NHS, including the requirement for all NHS trusts to appoint a Freedom to Speak Up Guardian (FTSUG), and the development of a single national integrated whistleblowing policy to help normalise the raising of concerns.

The trust had followed these recommendations and had an appointed FTSUG. The company secretary had taken on this role two years ago, alongside their current responsibilities as company secretary, and had not been allocated any dedicated time for the FTSUG role. The role had also not been advertised. There was a job description for this role, but no objectives had been set. The reporting line was through the chair of the audit committee, who was one of the NEDs.

Most staff were not aware of the role of the FTSUG or who the appointed FTSUG for the trust was. We saw, during our second visit to the trust, that screen savers with a photograph of the FTSUG and contact details were displayed on computers around the trust. When we looked on the trust’s intranet for an outline of the FTSUG role, we found that there was nothing under this title and no documents could be accessed. We found information under ‘Speaking in Confidence.’

At the time of the inspection, the trust had not carried out a review of the trust’s process. However, the speaking in confidence policy did give staff, who wished to raise concerns, different options which included:

- An anonymous email box. There were ten recipients and staff could choose who their concerns were sent to.
- Speaking to their line manager
- Speaking to a member of the executive team

There had been 12 concerns raised in 12 months prior to our inspection, three of which were live at the time of the inspection.

Duty of Candour

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. The majority of staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. Staff were aware of the trust’s policy and their requirement to apply duty of candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when duty of candour processes were triggered.

Our observation of records showed that when things went wrong patients, and their relatives, were offered a verbal and written apology, which complied with the duty of candour process. This also included arranging local meetings and support for patients and relatives.

We saw that copies of final investigation reports were shared with patients and their families.
Staff Diversity

Most staff at the trust in non-clinical and clinical (non-medical) roles identify as white. Around half of staff in clinical (medical) roles identify as BME.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Percentage of staff identifying as BME</th>
<th>Percentage of staff identifying as white</th>
<th>Percentage of staff with unknown ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical</td>
<td>15.0</td>
<td>81.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Clinical (non-medical)</td>
<td>28.0</td>
<td>65.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Clinical (medical)</td>
<td>47.5</td>
<td>43.0</td>
<td>9.5</td>
</tr>
</tbody>
</table>

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

The executive lead for equality and diversity was the chief people officer. A part-time equality and diversity lead had been appointed who reported to the chief people officer. They told us that they were fulfilling this role for one or two days a week whilst being a business partner for the medical division. The post holder was new, having been in the role for three months. The lead chaplain was supporting this. In addition, there was a vacant post for an equality and diversity advisor, and recruitment to fill this role was underway at the time of our inspection.

The trust’s equality and diversity strategy had not been updated since 2014. However, there was a draft equality and diversity strategy in place, which although had involvement of the senior management team, had not been devised in conjunction with any staff groups or networks. It had been reviewed by one NED, but was ‘work in progress.’ However, there was a combined equality and diversity and Workforce, Race Equality Standards (WRES) annual action plan in place which was comprehensive, up to date and fit for purpose. In addition, there was a WRES statement of commitment in place since July 2016.

Equality impact assessments were carried out against core trust policies. These identified if there was likely to be any impact on any of the protected characteristics, such as age, gender, race and sexual orientation, and to mitigate the likely impact.

We considered the workforce report in board papers dated January and March 2018, neither paper had any reference to equality and diversity.

From 6 April 2017, employers in Great Britain with more than 250 staff were required by law to publish their gender pay gap information, covering pay and bonuses. They were also required to publish this information on their website and via the designated government website. In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), East and North Hertfordshire NHS Trust had undertaken a gender pay gap review as of 31 March 2017. The
report demonstrated that on average, men were more likely to earn 13% more than women. The trust acknowledged where gaps could improve, for example, that there could be greater female representation in its senior medical roles and in their action plan stated that they would reassess their recruitment and selection policy and process for internal and external candidates to avoid any potential bias.

**NHS Staff Survey 2017**

In previous years, the trust’s staff survey cycle took up to seven months to complete, from the launch of the survey in October to sharing the associated action plans. This meant the trust was left with five months to implement and embed any changes until the next staff survey opened.

Due to the challenges the trust had faced in the previous 12 months (the implementation of a new electronic patient record computer system, the national cyber-attack and its financial challenges), the trust decided to take a more timely and inclusive approach to reviewing the results. The new approach enabled as many staff as possible to be involved in addressing the areas where the survey indicated improvements were needed.

As a result, the trust commissioned a new staff survey provider for the 2017 and 2018 staff survey. They provided a timelier analysis of the initial staff survey data, in an easily accessible format. Following the analysis, and with the support from the new provider, the trust commenced an online workshop for all staff. The aim of this workshop was to seek staff’s suggestions and ideas on key areas of improvement and organisational focus. The online workshop was open from 3 January 2018 and ran for approximately three weeks. All contributions to the workshop were completely anonymous.

**NHS Staff Survey 2017 Results**

The trust’s overall performance in the 2017 NHS staff survey was worse than their performance in the 2016 staff survey. The CEO told us that, although the results were disappointing, they were not a surprise. This was because the launch of the staff survey coincided with the implementation of the new electronic patient record computer system which had caused disruption throughout the trust.

Since the 2016 NHS Staff Survey there had been a decrease in performance for the trust in the overall staff engagement score (from 3.86 in 2016 to 3.69 in 2017) and in staff recommending the trust as a place to work or receive treatment (KF 1. from 3.79 in 2016 to 3.54 in 2017). In 2017 the trust falls in the worst 20% of acute trusts in both cases.

The trust had three key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey: In 2016 the trust had 14 key findings which were better than the average for similar trusts.
### NHS Staff Survey 2016 Findings

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.02</td>
<td>3.96</td>
</tr>
<tr>
<td>KF 3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF 4. Staff motivation at work</td>
<td>3.99</td>
<td>3.94</td>
</tr>
<tr>
<td>KF 5. Recognition and value of staff by managers and the organisation</td>
<td>3.52</td>
<td>3.45</td>
</tr>
<tr>
<td>KF 7. Percentage of staff able to contribute towards improvements at work</td>
<td>75%</td>
<td>70%</td>
</tr>
<tr>
<td>KF 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.97</td>
<td>3.92</td>
</tr>
<tr>
<td>KF 9. Effective team working</td>
<td>3.77</td>
<td>3.75</td>
</tr>
<tr>
<td>KF 12. Quality of appraisals</td>
<td>3.20</td>
<td>3.11</td>
</tr>
<tr>
<td>KF 13. Quality of non-mandatory training, learning or development</td>
<td>4.12</td>
<td>4.05</td>
</tr>
<tr>
<td>KF 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>33%</td>
<td>35%</td>
</tr>
<tr>
<td>KF 18. Percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td>KF 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.64</td>
<td>3.61</td>
</tr>
<tr>
<td>KF 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>KF 32. Effective use of patient / service user feedback</td>
<td>3.77</td>
<td>3.70</td>
</tr>
</tbody>
</table>
NHS Staff Survey 2017 Findings

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 12. Quality of appraisals</td>
<td>3.17</td>
<td>3.11</td>
</tr>
<tr>
<td>KF 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>KF 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>46%</td>
<td>45%</td>
</tr>
</tbody>
</table>

The trust had 22 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey: In 2016 the trust had seven key findings which were worse than the average for similar trusts. These were:

NHS Staff Survey 2016 Findings

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>KF 20. Percentage of staff experiencing discrimination at work in last 12 months</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>KF 23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>KF 24. Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>61%</td>
<td>67%</td>
</tr>
<tr>
<td>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>KF 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.66</td>
<td>3.72</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.54</td>
<td>3.75</td>
</tr>
<tr>
<td>KF 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.83</td>
<td>3.91</td>
</tr>
<tr>
<td>KF 3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>KF 4. Staff motivation at work</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>KF 5. Recognition and value of staff by managers and the organisation</td>
<td>3.39</td>
<td>3.45</td>
</tr>
<tr>
<td>KF 6. Percentage of staff reporting good communication between senior management and staff</td>
<td>24%</td>
<td>33%</td>
</tr>
<tr>
<td>KF 7. Percentage of staff able to contribute towards improvements at work</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td>KF 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.83</td>
<td>3.91</td>
</tr>
<tr>
<td>KF 9. Effective team working</td>
<td>3.65</td>
<td>3.72</td>
</tr>
<tr>
<td>KF 10. Support from immediate managers</td>
<td>3.70</td>
<td>3.74</td>
</tr>
<tr>
<td>KF 11. Percentage of staff appraised in last 12 months</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>KF 13. Quality of non-mandatory training, learning or development</td>
<td>3.98</td>
<td>4.05</td>
</tr>
<tr>
<td>KF 14. Staff satisfaction with resourcing and support</td>
<td>3.15</td>
<td>3.31</td>
</tr>
<tr>
<td>KF 15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>KF 16. Percentage of staff working extra hours</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>KF 17. Percentage of staff feeling unwell due to work related stress in last 12 months</td>
<td>38%</td>
<td>36%</td>
</tr>
<tr>
<td>KF 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.53</td>
<td>3.62</td>
</tr>
<tr>
<td>KF 23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>
KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months  
29%  
KF 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents  
3.56  
KF 31. Staff confidence and security in reporting unsafe clinical practice  
3.54  
KF 32. Effective use of patient / service user feedback  
3.66

For seven questions, the trust performance was similar to the national average in 2017.  
(Source: NHS Staff Survey 2017)

Workforce race equality standard 2017

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.

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></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>35%</td>
<td>27%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>78%</td>
<td>75%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>12%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Of the four questions above, three questions showed a statistically significant difference in score between white and BME staff.

These were:

- KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- Q17b – In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

Whilst part of the challenge had been to fill the trust’s vacancies, retaining existing staff had also received attention from the board. An example of this was a developmental programme, changing the organisation’s culture through the LEND (Listen, Empower, Nurture and Develop) which had been key to help deliver a supportive, coaching environment across all areas. Staff we spoke, who had attended the programme, praised it.

The trust entered data for the Workforce, Race Equality Standards (WRES) and it was reported that none of the nine indicators were worse than the national average. As a result of the WRES 2017 report, the trust had drawn up a combined equality, diversity and inclusion action plan, dated April 2017, which contained 40 actions. They were all red, amber, green (RAG) rated and had an executive sponsor.

We saw that:

- 16 were green and had been completed.
- 16 were amber, of which seven had passed their target completion date of 31 March 2018.
- Two were red.
- Six had not been started.
- 13 of those that were red, amber or had not been started, did not have a target completion date.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asked 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 trust scored slightly above the England average for recommending the trust as a place to receive care from November 2016 to October 2017.

(Source: Friends and Family Test)

The Friends and Family Test (FFT) responses were generally positive across the trust. However, response rates showed a large variation between locations and departments, with MVCC having the lowest response rate for all services managed by East and North Hertfordshire NHS Trust. The senior management team were aware that only small numbers of FFT forms were returned from MVCC, and they were considering other means of gaining feedback.

The FFT response rate for community maternity services was also poor. However, the service was acting to improve this. Improvement actions included community managers reminding staff of the importance of obtaining women’s FFT feedback at team meetings. The service had also launched a competition asking staff to come up with ways in which to increase response rates.

Sickness rates
From September 2016 to July 2017, the trust’s sickness rates were higher than the England average.
A detailed sickness absence action plan had been developed, including the launch of a revised policy. The new policy which provided a more consistent and robust framework for managing sickness absence was launched on 26 March 2018. This was supported by training sessions targeted at all managers who had a responsibility for managing sickness absence. Sessions were reported to have been well attended.

(Source: Board minutes May 2018).

General Medical Council – National Training Scheme Survey

In the National Training Scheme Survey by the General Medical Council, the trust performed worse than expected for two areas (induction and feedback) and the same as expected for the remaining 13 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

Although there were structures, processes and systems of accountability to support the delivery of the strategy and sustainable services these were not fully effective. Governance processes were not consistently operating effectively. Divisions were inconsistent in their governance processes whilst the trust had taken steps to standardise these processes, it was too early to assess the effectiveness of the changes at this inspection.
The medical director was the executive lead for patient safety although they worked jointly on governance with the director of nursing.

The risk and quality committee (RAQC) was the subcommittee of the board. A non-executive director chaired this. The committee had delegated responsibility for oversight of all aspects of quality. A number of other committees supported the RAQC in this role:

- Clinical governance strategy committee (chaired by the medical director)
- Patient experience committee (chaired by a non-executive director)
- Patient safety committee (chaired by the associate medical director for patient safety)
- Quality improvement board

For example, divisional risks of rated at 15 and above, would be discussed at the clinical governance strategy committee which reported to the RAQC. However, staff could not consistently articulate the roles of each committee and how information flowed between the committees therefore there was a risk of duplication or omission.

The trust had recognised that the way divisions were managing governance differed and they were working to standardise this with the new accountability framework being a key aspect of this. Due to the recent development of this we were not able to assess its effectiveness at this inspection.

A risk management strategy and a revised board assurance framework (BAF) had been approved at the March 2018 board meeting. It was noted that the BAF and corporate risk register were not presented at the board meetings. On review of the annual board cycle for 2017/18 it was noted these were not itemised for review at any of the board meetings.

The board assurance framework (BAF) was led by the trust's company secretary, who although was a not an executive had been nominated as its executive lead. The BAF was held by the audit committee and was reviewed monthly at the risk and quality committee (RAQC), divisional executive committee (DEC) and the finance and performance committee.

The risk management policy reflected the use and alignment of the BAF and corporate risk, to the trust reporting and assurance process. The BAF risks were drawn from organisational imperatives of:

- Finance
- Strategy
- Workforce
- Clinical, which included medicine and nursing.

All were related to the trust's corporate objectives:

- Delivering promises and value
- New ways of caring
- Developing the Mount Vernon Cancer Centre

(Source: Trust Board Assurance Framework)
The trust had developed a quality transformation plan (QTP). The QTP was described as transitional by the board, to help ensure there was engagement and continuous improvement. It was also aligned to patient safety, clinical risk management, reporting and learning.

The trust, in September 2017, had commissioned an external auditing company to consider the trust’s senior leadership, their risk management and governance. A number of recommendations had been made which had been considered by the board and were being worked through via an action plan.

There were gaps in how staff understood, reported and managed risk. However, the board recognised this needed improvement and confirmed it was a priority of the QTP. In addition, the divisions had inconsistent approaches to governance. However, despite this, the trust reported that the open culture and positive approach to risk management was something of which they were very proud.

Divisional risk registers and the BAF had a clear governance reporting framework in relation to risk ownership. This ranged from clinical divisions to corporate and sub-board committees. It was acknowledged by the board members we interviewed, that this process needed further review and support so it was fully embedded across all the trust’s work streams and to further enhance governance arrangements. It was planned that the QTP would support this process.

The BAF and risk register leads had regular engagement and interaction with the divisions to ensure they were both reviewed. There was limited evidence to demonstrate how mitigations from the risk register or the BAF were informing improvements. There was one exception to this, the trust’s IT stabilisation programme. This programme was commenced following the implementation of the new IT system and was structured around the risk register action plan.

Several board members told us that divisions had historically overstated their risk rating scores in the BAF. This was to increase their likelihood of being allocated capital expenditure to address the risks identified. As a result, the risk rating process had been reviewed and amended to prevent this from happening in future.

The pharmacy team was integrated into the trust’s governance structure. We saw that the medication forum reported directly to the trust’s patient safety committee, which in turn reported to the trust’s clinical governance steering group. Any concerns that required further escalation were then presented by the chief pharmacist to the RAQC.

**Management of risk, issues and performance**

Although the trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected, these systems were not always effective. For example, there was a lack of effective systems to recognise, assess and respond quickly to deteriorating patients, infection prevention and control measures were not adhered to and some equipment and environments were not appropriate to care for patients safely. In addition, there was a significant backlog of maintenance tasks that had been curtailed to save money.
The risk management strategy and procedure was reflected in the trust’s current policy, 2018-2021. However, the QTP, which was reported as key in transitioning the process, was not reflected in the risk management strategy. The corporate risk register was owned jointly by the service leads, a newly appointed band 7 risk manager and the company secretary. The risk registers were led at service line or divisional levels by the divisional leads. In turn, the divisional leads reported into the monthly divisional boards and were reviewed alongside the trust’s risk manager, who was the medical director. In addition, the risk register was reviewed monthly at the divisional quality committees, RAQC and the clinical governance and strategy committee (CGSC). It was not reviewed regularly at the board meetings. The risk registers had been recently aligned to the BAF and the corporate risk register. However, Mount Vernon Cancer Centre and the women and children’s division managed risk reporting using specific processes related to their services. This meant that all the divisions were not fully aligned and the trust board may not have always been aware of specific risks in these areas.

There was a comprehensive plan of risk management which included ‘risk clinics’, which were led by the director of nursing and the medical director. The trust’s risk team provided training to staff on how to effectively recognise, record and manage risk.

Risks were reviewed monthly at the divisional boards at performance review meetings and the CGSC. There was no evidence of how the trust staff would know or understand what was a risk and how it would be reported and managed. However, this had been recognised as a priority to address via the QTP.

The trust had recognised that it had an inordinate number of high scoring risks. This was described in board papers. There was recognition that some risks had been inflated by the divisions to draw attention to them and secure funding to expedite the purchase of essential equipment. It was also recognised that this compromised the trust’s ability to effectively rectify risks. This was because it limited the board’s ability to make informed decisions about its priorities. As of March 2018, one risk was documented as scoring 25. This risk related to compromised patient safety due to insufficient inpatient emergency capacity. There were 36 approved risks which scored 20. This was a reduction from 48 since the beginning of February 2018.

Within surgery and the urgent care centre we found there was a lack of effective systems to recognise, assess and respond quickly to deteriorating patients; infection prevention and control measures are not adhered to, which increased the risk of infection to patients; there was an ineffective medicines management process, specifically regarding the storage and administration of medication and some equipment and environments were not appropriate to care for patients safely.

**Safeguarding**

**There was a clear structure to recognise and support safeguarding concerns within most sites within the trust.**

There were separate named safeguarding professionals designated for both adults and children’s. This included a named nurse, a named doctor and a named safeguarding midwife for children’s safeguarding, and a named nurse and doctor for adult’s safeguarding. The safeguarding leads
reported directly to the director of nursing, who was the executive and strategic lead for safeguarding. The safeguarding leads were based at Lister hospital.

A social worker, employed by the trust, was based at MVCC and acted as the lead for adult safeguarding on site. They linked with the trust lead and the safeguarding team at Lister hospital. They also provided training for staff on site.

**Governance arrangements for safeguarding were clear.** There was a monthly, joint safeguarding committee for children and adults, chaired by the director of nursing. This committee reviewed policies, disseminated learning from reviews and discussed the trust’s safeguarding agenda. Representation at these meetings included: individuals from the clinical divisions across the trust, the trust’s child and adult’s safeguarding leads, the learning disability liaison nurse, the independent domestic violence advisor (IDVA), the trust’s dementia team and the CCG leads for adult and child safeguarding. The committee reported to the trust’s RAQC via the director of nursing. There were separate adult and children’s safeguarding groups that reported into the safeguarding committee. These included the learning disability group, the dementia strategy group and the child protection sub-committee.

We saw both the adult and children’s safeguarding policies were in date. The adult’s safeguarding policy included a referenced link to the statutory guidance to the Care Act 2014 and information about making safeguarding personal. ‘Making Safeguarding Personal’ was a sector-led initiative, which aims to develop an outcome focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. Both policies also referenced associated documentation and guidance, including the trust’s domestic abuse, Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) policies.

Safeguarding adults and children was part of the trust’s mandatory training programme. Level 2 adults safeguarding also included training on MCA and DoLS. **Data the trust provided us with prior to our inspection, showed poor compliance with safeguarding training, and this was confirmed during our inspection. The safeguarding leads were aware of non-compliance with safeguarding training targets. However, we were not assured there were robust plans in place to improve this.**

Risks relating to non-compliance with training were documented on the safeguarding risk register. However, staff told us this hindered attempts to improve compliance rates. This was because the safeguarding leads were not operationally responsible for the divisions and, therefore, had limited opportunities to address the risk. The safeguarding leads were trying to increase their presence within the divisions to rectify this. For example, the safeguarding leads were trying to attend the divisional meetings for the problematic areas, such as the emergency department.

Although there was poor compliance with mandatory safeguarding training, the trust offered additional non-mandatory training opportunities. For example, the adult safeguarding team ran additional monthly MCA and DoLS workshops on the Lister site. The team encouraged all qualified staff to attend to increase their skills about using MCA and DoLS in their practice. They also completed sessions for preceptorship nurses, clinical support worker apprentices, trainee nurse associates and the oversea nurses as part of their induction programmes. As of January 2016, 475 staff had attended this training.
In addition, the named doctor for safeguarding children implemented a peer review process for paediatricians and trainee doctors at the trust. At these monthly sessions, each child protection report was discussed, which helped to share learning and best practice.

Inter-organisational governance arrangements for safeguarding were in place. The trust was an active member of the local safeguarding board, represented by the director of nursing. The trust participated in the working sub-groups, safeguarding adult’s reviews and board activities. The safeguarding team also reported there was a good working relationship with the joint police and social care team and the IDVA, who was based on the Lister site Monday to Friday.

**Incidents**

From October 2016 to March 2017, the proportion of reported patient safety incidents that were harmful at the trust was similar to its national comparators. However, for the same period, the median time taken to report incidents was 30 days compared to 24 for all trusts.

During our inspection in March 2018, we reviewed the trust’s electronic reporting system and found a large number of historic incidents had not been completely reviewed and ‘closed’. There were 1,095 incidents overdue for review and 1,329 awaiting review.

- 34 of these related to incidents that occurred in 2016, of which six were recorded as serious incidents.
- 280 related to incidents that occurred in 2017.
- 919 related to incidents that occurred in 2018.

We reviewed six serious incidents in detail during our inspection in March 2018, four relating to 2017 and two relating to 2018. We found that none of the six had been closed. When we returned in April 2018, we reviewed four of these incidents and found that all four had still not been completed and closed. **It was clear that at the time of the inspection, the trust was unable to demonstrate comprehensive incident management on the electronic system.**

Although there was some daily oversight of incidents by a band 4 member of the governance team, this did not always take place if the individual was on annual leave. There was no formal process and no senior oversight. We discussed this with the director of nursing, who was aware that there was a backlog of incomplete incident investigations and had a plan in place to reduce these by the end of May 2018. In addition, the patient safety team had started to run a daily report on all incidents resulting a moderate harm or above. This information was then passed to the relevant leads for review, and scheduled for a final review with the serious incident panel. This ensured staff had identified the correct level of investigation and the duty of candour requirements were completed.

A new twice weekly serious incident learning panel had been introduced in March 2018. The director of nursing and medical director jointly chaired the panel. The purpose of this panel was to improve patient safety by:

- Reviewing reported incidents and commissioning the required level of investigation.
- Seeking assurance that urgent action had taken place to address the immediate safety of patients and reducing the risk of reoccurrence.
- Ensuring that the requirements for duty of candour are being followed.
- Providing assurance to the executive team and board that all serious incidents were appropriately declared and investigated.

Each incident was allocated an executive sponsor and a senior member of staff to lead the investigation and contact the patient, if appropriate. We attended a panel during our inspection and saw that ten incidents were presented, some were new and some were being followed up from the previous week. The incidents were discussed and an appropriate lead identified. Discussions included the investigation process, whether support and debriefs had been provided to the staff involved in the incident and whether duty of candour had been applied.

The panel had plans to extend the meeting once a month to authorise the closure of investigation action plans and to support timely closure of overdue actions.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income (£000s)</td>
<td>£384.7</td>
<td>£411.4</td>
</tr>
<tr>
<td>Full Costs (£000s)</td>
<td>£401.4</td>
<td>£440.9</td>
</tr>
<tr>
<td>Surplus (deficit) (£000s)</td>
<td>(£16.7)</td>
<td>(£29.5)</td>
</tr>
<tr>
<td>Budget (£000s)</td>
<td>(£8.0)</td>
<td>(£8.7)</td>
</tr>
</tbody>
</table>

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

The trust been through a challenging period financially but as a result their understanding of the financial position had significantly improved. The board now has an appropriate level of operational and financial experience and expertise across both the NEDs and executives. Sufficient board time was spent reviewing the trust’s finances however some found the information too detailed.

The board’s understanding of the financial position of the trust had significantly improved over the last 18 months. Prior to this improvement, the trust had a recent history of not meeting its financial plans, failing to properly scrutinise its underlying financial position, not fully understanding the financial implications of some of its decisions and was overly focused on its short-term financial position. A series of executive and non-executive board changes during late 2016/17 and 2017/18 led to an improvement in the board’s financial insight and the quality of the financial information. As a result, the trust’s financial decision-making abilities significantly improved. However, despite this, the trust did not deliver its 2017/18 financial plan. This was predominantly due to the
operational and financial consequences of the implementation of its new electronic patient record computer system.

The board now has an appropriate level of operational and financial experience and expertise across both the NEDs and executives. Sufficient board time was spent reviewing the trust’s finances and there was also a separate monthly finance and performance committee (FPC).

The director of finance was appointed in October 2016, and was appropriately qualified in terms of professional skills and qualifications. In addition, the director of finance had good operational understanding.

There had been considerable changes to the structure and composition of the whole finance team. The trust planned to further strengthen the finance team by recruiting substantively to vacant posts and further embedding finance and the project management office (PMO) staff into the trust’s divisional structure. This approach would create a more effective “business partnering” approach. The trust had a clear and improved process for short-term financial planning, which considered both internal and external influencing factors and interlinked with the trust’s overall strategy. However, by its own admission, the trust made a slow start to the development of its cost improvement programme (CIP) for 2018/19, due to poor initial engagement from the divisions.

NHS Improvement’s ‘Model Hospital’ benchmarking tool identified the trust as an outlier on medical staff costs, non-pay costs, finance/human resources departmental costs and procurement. However, the trust’s CIP programme and long-term financial strategy included the exploration of cost reductions in these areas. In addition, the trust is part of the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP). System-wide initiatives were being developed that will lead to patients, within the STP footprint, receiving more joined-up and innovative services, which have made effective uses of the resources available. An example of this was to use named agencies only for engaging locum staff to keep costs at a minimum.

During and prior to 2016/17 there was a lack of awareness amongst operational and clinical management/staff regarding the financial circumstances of the trust. Furthermore, during this period, the clinical divisions had considerable autonomy and there was insufficient divisional or central financial control.

In 2017/18, given the scale of the financial challenges faced by the trust and the consequent change in financial oversight and scrutiny from NHS Improvement, the trust implemented a short-term financial recovery plan involving centralised financial controls over divisional control. During this period, the trust also received support on financial turnaround from an external professional auditing company. In addition, the trust also sought support from another external company specialising in clinical efficiency and effectiveness. As part of this, there was considerable improvement in the communication and engagement of the trust’s financial plans and position with frontline staff. However, this dramatic change in financial culture, restricted divisional autonomy and damaged relationships between the divisions and the central finance team.

At the time of our inspection, many senior staff were still suspicious of all the financial controls that had been introduced. Those that we spoke with realised that something needed to be done to realign the trust’s finances and agreed there had been some good outcomes with regards to
reviewing expenditure and managing costs of equipment and consumable items. However, many senior staff told us that there were delays obtaining essential items as every item or project that had a cost associated with it had to go through a ‘finance committee’. None of the senior staff we spoke with had undergone financial training. This meant they lacked skills and awareness regarding financial matters.

Relationships between NEDs leading on financial areas (audit committee and FPC chairs) and the director of finance were appropriate, supportive and challenging. Board members we interviewed had a consistent view of the financial position of the NHS trust, with a shared understanding of the reasons for the trust’s under-performance against plan during 2017/18.

The audit and FPC committees had clear roles and responsibilities, and provided the board with appropriate assurance. Internal audits were determined by the audit committee on an annual cycle based on key risks. Audit committee meetings included the review of internal controls, the review of risk management processes (including the risk register) and the review of financial controls. Internal auditors were required to attend all audit committee meetings and on some occasions external auditors also attended.

A good level of information was available at board level and this included a summary of the financial position of the NHS trust. However, NED interviewees felt that the financial information at board and FPC was too detailed. They expressed intentions to make board and committee reports more succinct, more focused on key issues and to include key metrics on divisional performance.

The new accountability framework for 2018/19 described how the responsibility for and monitoring of financial performance and use of resources was managed, and how divisions would be held to account for their financial delivery.

Divisions were involved in the 2018/19 budget setting process. The 2018/19 CIP plans were informed by benchmarking against the NHS Improvement’s Model Hospital data.

A business intelligence project was initiated in late 2016 to support the development of better operational, finance and workforce reports. As part of this project, the trust rolled out a system which gave clinicians and managers access to a wide range of reports.

As noted above, a good level of information was available at board level and this included a summary of the financial position of the trust. However, NED interviewees felt that the financial information at board and FPC was too detailed. They expressed intentions to make board and committee reports more succinct, more focused on key issues and for them to include more key metrics on divisional performance.

We interviewed the director of finance who was aware of the size of the financial challenge for the trust to deliver its financial plan and reduce the size of its deficit in 2018/19.

**Trust corporate risk register**
The trust provided a document detailing their 12 highest profile risks.
Corporate objective one: *delivering our promise on value and quality.*

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Target risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/2018</td>
<td>001/18</td>
<td>There is a risk the within the context of the healthcare economy the trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62 day cancer, RTT and the A&amp;E 4-hour standard</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>01/04/2017</td>
<td>003/18</td>
<td>There is a risk that the trust is unable to achieve financial performance in 2017/18 as a result of not securing the required efficiency improvement within its cost improvement plan and its income</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>01/04/2017</td>
<td>004/18</td>
<td>There is a risk that the trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 2017/18</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>01/04/2017</td>
<td>005/18</td>
<td>There is a risk that the trust’s IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>002/18</td>
<td>There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>006/18</td>
<td>There is a risk that there is insufficient capital funding to address all estates backlog maintenance, including fire estates work, and funding for medical equipment</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>007/18</td>
<td>There is a risk that the governance structures in the trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the board’s objectives</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>008/18</td>
<td>There is a risk that the trust is not adequately prepared to deal with a major incident or emergency</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>
Corporate objective two: *new ways of caring.*

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Target risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/2018</td>
<td>011/18</td>
<td>There is a risk that the trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>009/18</td>
<td>There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the trust’s ability to deliver the required improvements and transformation</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>01/03/2018</td>
<td>010/18</td>
<td>There is a risk that the healthcare economy does not work effectively to redesign new models of care, which impacts on the hospital’s ability to manage demand for services</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

Corporate objective three: *develop the Mount Vernon Cancer Centre*

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Target risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/2018</td>
<td>012/18</td>
<td>There is a risk that the trust is not able to secure the long-term future of the MVCC</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>

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

**Information management**

Although the trust collected, analysed, managed and used information to support its activities, it had significant issues with data quality. The introduction of a new electronic patient records system had been problematic. To address this, the trust had developed a stabilisation plan to mitigate the risks and appointed a stabilisation director, to coordinate activity surrounding it.

The trust recognised it had significant issues with the quality of its data. A number of actions had been taken to improve this. An information assurance group had been established which met weekly to address clinical, operational and financial information and performance. Data quality
was a key aspect of this group’s remit. A data quality team had been created with a head of data quality and two data quality officers recruited. Their remit was to work with operational, clinical and support colleagues to focus on the use of the trust’s systems to reflect the care provided to patients in an accurate and timely manner.

The trust’s assurance framework and risk register included risks associated with the management and control of information. The trust also had an information governance statement of compliance agreement that supported the confidentiality, integrity, security and accuracy of personal data. The agreement included the independent review of systems and access to ensure authorised usage.

The FPC met monthly and had a membership of three NEDs who held the executives to account for effective progress in managing data quality.

The data quality policy and data quality framework outlined the strategic direction for the trust data quality agenda, and the responsibilities of all staff from executive level down.

The trust had reported two information governance serious incidents to the Information Commissioner’s Office. These incidents were due to a breach of confidentiality during 2017 and both related to a member of the public finding ward handover sheets, which they returned to the trust. Both incidents were investigated fully and the root cause was identified as human error. The handover sheets contained three personal identifiers, but very limited clinical information. Actions taken by the trust to mitigate the risk of reoccurrence included a communications campaign to remind staff on safe disposal of confidential waste at the end of their shift, and the number of personal identifiers used on handover notes was reduced to two. In addition, the trust has a long-term commitment to the implementation of digital technology to reduce the requirement for printed handover sheets.

In May 2017, the trust, along with 34% of other trusts experienced a cyber-attack, which resulted in a complete loss of IT and some telephone systems. Over a number of days, the trust initiated their major incident plan and recovery processes to help reintroduce the systems and normal activity resumed six days later. The trust reported that no patient data was compromised and there had not been any patient harm reported because of the major incident.

During our inspection, the trust lost their IT and telephone systems across all their sites, and a major incident was declared. The source of the fault, a piece of faulty hardware, was swiftly found and replaced in a systematic way to reduce further disruption. We saw that the response to the incident was considered, timely and well organised. The incident was ‘stood down’ after 36 hours, once the executive team had evidence that IT systems had been restored. There were more problems with some IT systems following this, however, they were managed as they happened, it was not necessary to declare a further major incident.

One of the trust’s major risks, which was scored as 20, was the introduction of a new electronic patient record computer system in September 2017. The trust acknowledged, in hindsight, that their response to the problems it generated was slow and it was introduced at a time when the hospital was planning and managing their winter pressures.
At first the trust could not be assured that:

- Patients were receiving appointments to the correct outpatient clinics and that individual clinics existed.
- Some clinics were under or overbooked.
- There was accurate recording and validation of breach referral to treatment times (RTT).
- Patients were on waiting lists for consultation or treatment who may have come to harm whilst waiting.
- Not all wards/departments were compliant with “real time” data entry. The operational site team relied on phone calls and ward visits to assess true picture of bed state.
- Medical outliers (patients managed outside of their appropriate bed space) were being accurately recorded.
- Discharge letters were being generated and sent to GPs.

The trust developed a stabilisation plan to mitigate the risks surrounding the new IT system and appointed a stabilisation director, to coordinate activity surrounding it. They commenced employment in January 2018. The stabilisation plan was monitored and co-ordinated through a stabilisation committee which met twice weekly and provided monthly progress reports to the trust board and FPC. In addition, the trust reviewed its plan with external bodies, such as NHSI and NHS Digital.

A central data point had been devised for tracking all potential harms to patients. At the time of the inspection, there had been 80 patients who had waited longer than 52 weeks for treatment, of those, 34 had received treatment and been discharged. Harm reviews had been carried out and three patients had been declared as suffering harm because of their wait. These were all being treated as serious incidents.

**Engagement**

Although the trust engaged with patients, relatives and the public to plan and manage appropriate services at Lister hospital we were not assured that the same level of engagement occurred at all the trust sites.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust had a patient engagement strategy in place, which was due to expire in April 2019. At the time of our inspection, the patient experience team told us they had already started to think about engagement for the next strategy, which coincided with the review of the trust’s main strategy.

The 2015 to 2019 strategy recognised that patients and carers were important to the healthcare and decision-making processes of the trust. The aim of the strategy was to actively engage with patients, carers and the community and improve communication between these groups of people. Patients were encouraged to be involved, and had attended trust board meetings. A patient story was heard and discussed at each trust board meeting and sometimes, the story was presented by the patient themselves.
When the trust had been considering a foundation trust application it had developed a public membership although the application had not progressed the trust recognised this membership as a valuable asset and indeed the membership had grown over the last five years.

Patients, families and carers could provide feedback using NHS choices and the friends and family test.

Child friendly feedback forms were also handed out to children to gauge their perception of the care and treatment they had received. The trust had a children’s and young people’s forum where patient views were actively sought. All the toys, equipment and furniture in the children’s playroom, adolescent and oncology rooms had been chosen by the children using the service.

We were told about an innovation on Barley ward that was a result of collaboration between staff, patients and relatives to improve the patient experience. Ward staff initiated a forum for patients and carers to share feedback about care, behaviours and outcomes that they would always expect during their inpatient stay. This information was shared to create a charter of ‘always events’ that detailed what patients should expect during their hospital stay.

The patient experience committee met regularly at Lister hospital, was well attended and considered changes in services to improve the patient experience. For example, the group reviewed themes arising from complaints, national and local surveys and concerns raised through PALS. The committee also ran regular workshop sessions at Lister hospital, where specific members of staff would present and discuss pertinent topics with the patient experience representatives, for example, the new electronic patient record computer system. Whilst we saw good engagement from the trust’s patient experience team with staff, patients and the public at Lister hospital, we were not assured that this was consistent across all the trust’s sites.

There was also a carer focus group, which fed directly into the patient experience committee. This group met quarterly and had approximately 20 attendees. Attendees included carer representatives and staff from the neighbouring community and mental health trusts. The group had recently helped to design a new carer handbook for implementation across the three trusts. The communications team maintained a high social media profile and were increasingly using this as an additional means of engaging with the local population, for example, during poor weather in the winter of 2017/18, the trust updated their website daily to inform patients of any changes to appointments.

The trust had a large cohort of over 600 volunteers who actively engaged with patients, relatives and carers. The volunteer responsibilities included ensuring that patients and visitors knew where they were going, talking to patients on the wards and performing administration tasks.

The trust collaborated with partner organisations effectively. The trusts within the sustainability and transformation partnership were working towards appropriate standardisation of integrated clinical pathways to eliminate variation and optimise clinical effectiveness and efficiency.
The trust worked with external stakeholders and commissioners to improve engagement with the public. This included engagement with the local health economy. Several of the key executives were involved in various work streams run by local STP. Although work within the STP was still in early stages, there was a series of principles agreed by the STP’s members and associated actions; for example, elimination of unwarranted variation with clinical standards. All the associated trusts were working towards appropriate standardisation of integrated clinical pathways across the STP to eliminate variation and optimise clinical effectiveness and efficiency. Other examples included sharing education with other local trusts within the STP footprint. The trust was accepted in collaboration with the STP to be a pilot site for the trainee nursing associate programme. There were 64 trainees across the STP, 17 candidates had commenced the two year programme at ENHT.

The trust had clinical partnerships with other trusts in Hertfordshire, East Anglia and London to provide specialist care in centres of excellence.

**Whilst the trust had a number of mechanisms for engaging with staff not all ward managers held regular team meetings with all their nursing team. This meant there were limited opportunities for staff engagement, and to share and embed learning.**

Regular newsletters, emails and notices in staff areas ensured ongoing staff engagement took place; this included “you said, we did” notice boards. Communication systems, such as the trust’s knowledge centre (intranet), social media and bulletins were in place to ensure staff had access to up-to-date information about the work of the trust. Some staff told us they had the opportunity to provide feedback to their managers during team meetings or appraisals. However, not all ward managers held regular team meetings with all their nursing team. This meant there were limited opportunities for staff engagement, and to share and embed learning.

‘Star Awards’ were held monthly as a celebration and recognition of individuals and teams for their achievements and service improvements. This staff award system had been implemented following the last staff survey, and aimed to drive improvements across the trust, strengthen staff engagement and provide an opportunity to share experiences internally.

**Learning, continuous improvement and innovation**

The trust had systems and processes in place for improving the quality of care, however this had not developed into a continuous improvement programme. Learning from incidents, including serious incidents and never events, was not embedded or robustly followed-up to ensure they did not happen again.

The trust gave innovation and research priority as they recognised it was pivotal to enhance patient experience and outcome, and the trust was an important part of the National Institute for Health Research (NIHR). The trust worked with a wide range of funders to encourage broader investment in health research. This included work with a number of charities and the life sciences industry to help patients gain earlier access to breakthrough treatments. *(Source: 2016/17 annual report).*
We learned of substantial research activity at the trust, which employed 20 whole time equivalent nurses/staff within the research team. Improvement work included participation in research projects and recognised accreditation schemes. During 2017, the trust had 161 research projects underway, which involved more than 2,700 patients. We saw that some of these research projects had a positive impact on patient care. For example, the renal team established a share care space in haemodialysis. Some patients were trained to set-up their own dialysis machines in the renal unit, self-needle, put themselves on the machine and take themselves off the machine.

We saw that continuous improvement and research was particularly evident at Mount Vernon Cancer Centre (MVCC) where there were many research projects taking place. Nationally, MVCC were in the top 100 trusts for research. In addition, staff told us that at an international conference, MVCC was recognised as a leading contributor to cancer research.

Ideas to improve efficiency and cost improvement were encouraged from staff within all divisions. For the 2018/19 financial year, the trust held a one million pound ‘incentive pot’, which was used to reward divisions when staff designed efficiency schemes. However, some of the divisional leads we spoke with raised concerns that any innovations that were not expected to deliver in-year savings were not given appropriate consideration by the executive team and were refused implementation.

There were processes to monitor which staff had attended both mandatory and non-mandatory training, and to remind staff when their essential training was overdue. However, during the core service inspection and focus groups, most staff told us that there was no time for them to undertake training or development due to clinical and financial pressures. Overall compliance with mandatory training at the trust was 83%, which was worse than the trust’s target of 90%. There was a strong need for the trust to further embed learning from never events and serious incidents. Despite divisions completing investigation reports and action plans following a serious incident or never event, there had been inconsistent follow-up of these to ensure any learning identified was embedded and followed by staff. This was supported by the repetition of two separate almost identical never events. The executive team was hopeful that learning from incidents and embedding learning would significantly improve once the serious incident panel was fully embedded.

The trust had appropriate systems and processes in place for the management of complaints and the responses we saw were thorough, addressing all the points that had been raised and were sympathetic to the complainant. However, the trust did not always act in accordance with the Data Protection Act when dealing with complaints not ensuring the complainant had a legal right to seek confidential information.

Complaints process overview
The director of nursing was the executive lead for complaints management. There were five whole time equivalent staff dedicated to complaints management within the trust. When a complaint was reported to the complaints team, they sent the complaint to the relevant division who allocated an investigating officer. This would either be a ward manager or a consultant. Staff told us that engagement with the divisions and the ownership of complaints needed improvement, particularly
within the surgical division. At the time of our inspection, there were 142 open complaints with 70 of these belonging to the surgical division.

The complaints team confirmed that all draft responses were checked and challenged by the director of nursing or the chief executive officer (CEO), and gave us examples of when responses had been rejected by them and consequently amended.

Information was available to patients, relatives and visitors about how to make a complaint or how to contact the patient advice liaison service (PALS). For example, there were leaflets in clinical and non-clinical areas, complaints in waiting areas and information on the trust website. Staff were aware of the process for supporting patients in making complaints.

PALS offered confidential advice and support to patients, visitors and staff. They provided a point of contact for people to help resolve concerns before they became formal complaints. The team also provided information about how to make a formal complaint, as necessary. The PALS office was based on the same level as the main entrance to Lister hospital and comprised of two small rooms. The team informed us that this was a good, central location. However, they reported that due to the size of the office, it was not always accessible to all patients and visitors, for example, wheelchair users. We also saw this during our inspection. In addition, conversations held in each room could be overheard. This meant that confidentiality could not always be maintained.

Staff told us that most of complaints reported to PALS were due to communication issues from nursing and medical staff. Most of these complaints were resolved and responded to immediately. All concerns or complaints reported to PALS were recorded on the trust’s electronic incident reporting system.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>80%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Negotiated with complainant</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,760</td>
<td>November 2016 – November 2017</td>
</tr>
</tbody>
</table>

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

The trust did not always act in accordance with the Data Protection Act when dealing with complaints. We reviewed 10 complaint responses and found that all complaints had an apology.
from the trust, stated who had investigated the complaint and how the complainant could take their complaint further, if required. We saw that where possible the complaints team telephoned the complainant initially to understand the complaint further and reassure the complainant that their concerns were going to be investigated. In appropriate cases, complainants were offered a meeting with staff members and were provided with a copy of the action plan to show how the trust had learnt or were going to learn from the concerns raised. There had been no complaints raised to the Parliamentary and Health Service Ombudsman in the past year.

All the responses we saw were thorough, addressing all the points that had been raised and were sympathetic to the complainant. However, we saw two complaints where the patient was deceased and their relative had complained. Although one had evidence of verbal consent and the other written consent declaring they were a relative of the deceased, there was no evidence that the complainant had a legal right to seek confidential information on behalf of a third party, for example by a power of attorney document or evidence that they were the executor of the patient’s will.

**Number of complaints made to the trust**

From November 2016 to November 2017, the trust received 768 complaints.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>278</td>
<td>36%</td>
</tr>
<tr>
<td>Surgery</td>
<td>130</td>
<td>17%</td>
</tr>
<tr>
<td>Urgent and Emergency Services</td>
<td>114</td>
<td>15%</td>
</tr>
<tr>
<td>Medicine</td>
<td>99</td>
<td>13%</td>
</tr>
<tr>
<td>Maternity</td>
<td>49</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>5%</td>
</tr>
<tr>
<td>Unassigned Core Service</td>
<td>27</td>
<td>4%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>21</td>
<td>3%</td>
</tr>
<tr>
<td>Services for Children and Young People</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>3</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>2</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td>End of life care</td>
<td>0</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>768</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints)
Learning from deaths

The trust complied with the latest national guidance with regards to learning from deaths.

We assessed how the trust learnt from reviews and investigation of deaths. The approach tests the progress NHS trusts have made in meeting national guidance issued on March 2017 on learning from deaths, that sets out what families and carers should expect, and highlight any good practices.

From September 2016 to August 2017, the trust’s crude mortality was 1.62% compared to 1.67% for the latest three years.

HSMR (data period July 2016 to June 2017) for the 12 month period was 94.92 and is statistically ‘as expected.’

HSMR – Peer comparison East and North Hertfordshire NHS Trust is ranked fifth (out of 16) in the East of England Peer group compared to sixth out of 17 in the last report.

SHMI (data period April 2016 to March 2017) for the 12 month period is 102.69 - ‘as expected band 2.’
(Source: Dr Foster Intelligence Portal)

There was a learning from deaths policy dated October 2017, which set out the scope, purpose and individual responsibilities with regards to deaths. The medical director was the executive lead for learning from deaths. The trust had implemented a learning from deaths mortality report that was first presented at the November 2017 board meeting. The report was thorough and described in detail HMSR and SHMI data, what was being done to minimise risks to specific patient groups and key risks within clinical specialities, for example patients who presented with both chronic and acute lung conditions. They had also identified that patients presenting with myocardial infarction (heart attack) had a higher mortality from July 2016 to July 2017. Out of 60 deaths reported, 43 were expected, and this showed an ‘excess’ of 17, which pushed the SHMI for that speciality to 140. (Source: Dr Foster Intelligence Portal)

The trust had invited the Royal College of Physicians to conduct a review. It was reported that they did not have a concern with regards to cardiology mortality.

The trust had trained 32 mortality reviewers drawn from medicine, surgery and anaesthesia. As a general principle, consultants did not review the deaths of patients who had died under their care, although sometimes had to provide information to other reviewers regarding the patient. Mortality reviewers were responsible for conducting the Stage 1 review of deaths in scope. This included the identification of concerns relating to care which triggered a Stage 2 review. In line with national guidance, if a person died, who had a learning disability or mental health needs and required acute care, they were subject to specific reporting. This was all described in the trust’s policy.

Prior to November 2017, deaths of patients, who had sustained a fractured neck of femur and those who had died at MVCC, were reviewed separately in their specialist areas. This was due to established processes being in place and partly due to each requiring bespoke elements to these
particular reviews. To comply with the requirements of the 2017 national guidance, the outputs of these reviews had been added to the central data for reporting purposes.

The trust also worked in tandem with the local clinical commissioning group (CCG) on specific mortality reduction initiatives through the mortality review group. This forum provided external partners with the opportunity to discuss and review all the trust’s activities aimed at reducing mortality, and to make requests and recommendations, as appropriate. The CCG had reduced the frequency of these meetings as they had increased confidence in the trust’s performance.

An extensive demand and capacity review was currently in progress. This review used external expertise to ensure sufficient bed, theatres and outpatient capacity was in place during 2017/18, to meet the commissioned levels of activity.

Accreditations

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made if 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 trust’s services have 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>Endoscopy, The New QEII and Endoscopy, Lister Hospital</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>We are aspiring to achieve accreditation for Lister, HCH and QEII sites - diagnostic radiotherapy</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>UKAS accreditation blood sciences -Feb final assessment</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>Mount Vernon Cancer Centre</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations)

The trust used several external agencies to support its improvement. Prior to our inspection in March 2018, the National Neonatal Quality Assurance Peer Review Team inspected the neonatal unit. The team undertook inspections of all neonatal units in England, to ensure there was consistency and to allow sharing of best practice.
Facts and data about this service

The emergency department (ED) at East and North Hertfordshire NHS Trust is located at the Lister Hospital. It provides a 24 hour, seven days a week service to the local population.

The department has a reception and waiting room with two triage rooms. There are 12 cubicles and four side rooms in the major’s area; there is also a ‘sub-wait’ area within majors for ambulatory major’s patients to receive treatment. There are four consulting rooms and a designated eye room in minors and six bays in the resuscitation room, one of which is a side room. Within the adult ED there is a six bedded clinical decisions unit (CDU) with a seated area. There is also a compliant mental health assessment room, which is situated within majors.

The department has its own separate children’s ED with a separate waiting area, three assessment bays, a side room for triage and two bays in a resuscitation room. There is also a children’s assessment unit (CAU), if children needed further observation and tests. The CAU has six beds, one treatment room and a room for relatives and carers. The CAU also receives children referred directly from GPs and midwives.

Our inspection was unannounced to ensure to observe routine activity. During our inspection, we used a variety of methods to help gather evidence to assess the urgent and emergency care services at Lister Hospital.

We visited the adult, children’s ED, CAU and CDU. We spoke with 30 members of staff, 10 patients and four ambulance crews. We also reviewed 16 sets of patient’s electronic records.

We interviewed the clinical lead consultant, matron, head of nursing for emergency medicine, the general manager, divisional director and chair. We spoke with professionally qualified and support staff. We observed the environment and the care provided to patients. We also looked at a wide range of documents including, policies, meeting minutes, audits and action plans.

Details of emergency departments and other Urgent and Emergency Care services

- The QEII – Urgent Care Centre
- Lister Hospital- Emergency Department, children’s ED and Children’s Assessment Unit (CAU).

(Source: Trust Routine Provider Information Request)
Activity and patient throughput

Total number of urgent and emergency care attendances at East and North Hertfordshire NHS Trust compared to all acute trusts in England.

There were 159,019 attendances from April 2016 to March 2017 at East and North Hertfordshire 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 that resulted in an admission fell from 2015/16 to 2016/17. In both 2015/16 and 2016/17, rates were higher than the England averages. (Source: NHS England)

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

* 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 01/10/2016 - 30/09/2017)

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff’s compliance with mandatory training had improved since the last inspection in 2016. However, medical staff’s compliance was below the trust’s target in some modules.

The trust had a programme of mandatory training that all staff had to complete. Mandatory training consisted of fire safety awareness, infection control, information governance, manual handling, equality and diversity and conflict resolution. Courses for mandatory training were online and face-to-face teaching sessions. The trust had a rolling training mandatory year.

The trust’s target was 90% for mandatory training. Over 90% of adults and children’s ED nursing staff had up to date training in all the mandatory training modules, except for information governance, manual handling refresher, equality and diversity and fire safety. This had improved since the last inspection.

The department’s education facilitator had left the trust, and with an increased demand in ED attendances and reduced flow in the department, it had been recognised that there had been a fall in mandatory training. Even though only slightly under the trust’s target. Alternative training methods were identified.
Senior staff told us that there were plans to deliver bespoke training sessions for ED staff and plans to allow staff time to complete specific training. The department had added additional training into team meetings and implemented team champions to deliver training during shifts when the department was safe to do so. This had been recognised for the medical staffing mandatory training also. The department’s trajectory for the end of April 2018 was to meet the 90% standard and this was on course.

The nursing staff were split into teams, with a band 7 (senior sister) as the team leader for each group. They knew who needed to receive mandatory training and relevant life support modules.

The tables below show the completion rates for each of the mandatory training modules for all staff in the emergency department.

**Mandatory training completion rates**

A breakdown of compliance for mandatory courses from April to October 2017 for medical/dental and nursing/midwifery staff in all urgent and emergency care throughout the trust is shown below:

<table>
<thead>
<tr>
<th>Training courses</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>48</td>
<td>64</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>48</td>
<td>64</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>48</td>
<td>64</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>48</td>
<td>64</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>36</td>
<td>64</td>
<td>56.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>25</td>
<td>64</td>
<td>39.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>13</td>
<td>64</td>
<td>20.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 59.4%. Of the seven mandatory training courses delivered by the trust to medical and dental staff, none met the completion rate target of 90%. We looked at the action plan for improvement and this included, assigning targets to the medical staff’s line managers, initiate ‘focus weeks’ for training and to improve the access and knowledge of the online training system. The trajectory of compliance for May 2018 was 95%.
## Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training courses</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>151</td>
<td>160</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>151</td>
<td>160</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>149</td>
<td>160</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>148</td>
<td>160</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>142</td>
<td>159</td>
<td>89.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>140</td>
<td>160</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>137</td>
<td>160</td>
<td>85.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>125</td>
<td>160</td>
<td>78.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff was 89.4%. Of the eight mandatory training courses delivered by the trust to nursing and midwifery, four met the completion rate target of 90%.

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

We spoke with four members of staff regarding mandatory training. They told us that they were able to access mandatory training, and that training opportunities were available within the department.

The trust had a sepsis policy, which the ED staff knew how to access. There was a yearly sepsis management training module. As well as further training in managing sepsis in acute oncology patients. They used sepsis screening tools and sepsis care bundles. In the children's ED there were specific screening tools depending on the age of the child.

The compliance for sepsis training was only at 53%. However, we saw evidence of a training plan that had commenced. This included; update training sessions for all staff, this was planned for May, June and July 2018. One of the hospitals sepsis nurses was working alongside the junior and newly appointed nurses, to assist them in assessing unwell patients and identifying and treating sepsis.

With support from the matron’s, the focus of recent sepsis training had been on, prompt assessment of patients, screening for sepsis whenever a patient showed signs of infection, prompt escalation to a doctor, and prompt administration of antibiotics by the trained senior nurses. The sepsis nurses were going to carry out the CQC sepsis six audit this year.

Sepsis updates and training was delivered to doctors of all grades and we saw evidence of these teaching modules.

All staff we spoke with understood sepsis and the importance of early recognition.
Safeguarding

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

However, safeguarding training for medical staff was below the trust targets. However, when we spoke with staff, all knew the processes and policies in place to protect their patients from abuse and worked well with other agencies to do so.

The department had processes in place to ensure adults and children in vulnerable circumstances were safeguarded from abuse and harm. There was an up to date policy and staff could access the safeguarding lead for the trust for advice.

Across the adult and children’s ED, there was a clear system and process in place for identifying and managing patients at risk from abuse. This was in line with the trust’s policy for safeguarding adults and children. Nursing, medical and administrative staff we spoke with were able to explain the process of safeguarding a patient and provide us with specific examples of when they would do this.

There was clear guidance on recognising signs of specific abuse on display in both the adult and children’s ED. This included whom to contact internally and externally with concerns. We saw information in relation to female genital mutilation in line with the World Health Organisation guidelines. There was specific guidance for caring for patients who presented with non-accidental injuries for children and adults.

Nursing staff met the trust’s compliance target for training in levels 1 and 2 for adult and children’s safeguarding. However, it was seen in the data provided that the percentage of staff completing level three children’s safeguarding had fallen to 78% for nurses and 61% for the medical staff.

Extra courses were being provided. We spoke with the band 7 staff who were in charge of the adult ED, during our inspection and they had completed level 3 children’s safeguarding training. They told us, although not all staff had completed yet, there was always someone on the shift who had. However, in the adult ED they did not treat children, but trained staff to level 3 children’s safeguarding. The nurses and paediatric doctors that worked in the children’s ED had all completed level 3 children’s safeguarding training.

The completion for level 1 and 2 training in children’s safeguarding was 98% for nursing staff. In level 2 training, staff were taught the processes of recognising abuse and referring appropriately to the right staff and authorities. All staff we spoke with knew this process in detail. Staff could name the safeguarding lead and felt comfortable raising concerns. However, medical staff compliance for children’s safeguarding level 2 was at 61%. The trust had recognised this as a concern and had an action plan for completion by May 2018.

All patients under 18 were checked on the child protection register. If a child was known to child protection teams this would be flagged on the ED electronic booking in system. We saw examples of referral forms completed. An external health visitor came to the department weekly and looked at all referrals made. The safeguarding local authority was available for the staff to access 24 hours a day, seven days a week.
On the electronic patient records, there was a detailed section of safeguarding risk assessments for both adults and children.

**Safeguarding training completion rates**

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

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

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and nursing staff in East and North Hertfordshire NHS Trust is shown below:

**Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Training Courses</th>
<th>Number of medical staff trained (YTD)</th>
<th>Number of eligible medical staff this year</th>
<th>Proportion of Training</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>41</td>
<td>64</td>
<td>64.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>41</td>
<td>64</td>
<td>64.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>11</td>
<td>18</td>
<td>61.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>29</td>
<td>64</td>
<td>45.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>29</td>
<td>64</td>
<td>45.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust's overall medical safeguarding training completion rate was 55.1%. The trust did not meet the completion rate target for any of the safeguarding modules it delivered.

**Nursing and Midwifery Staff**

<table>
<thead>
<tr>
<th>Training Courses</th>
<th>Number of nursing staff trained (YTD)</th>
<th>Number of eligible nursing staff this year</th>
<th>Proportion of Training</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>157</td>
<td>160</td>
<td>98.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>155</td>
<td>159</td>
<td>97.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>149</td>
<td>160</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>148</td>
<td>159</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>113</td>
<td>145</td>
<td>77.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust's overall nursing safeguarding training completion rate was 92.2%. The trust met the
completion rate target for four out of the five safeguarding modules it delivered.

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

Staff were aware of the Mental Health Act and the holding powers that doctors and nurses have. They would always get the advice from their mental health colleagues if required. There were policies and procedures in place for extra observation, restraint and rapid sedation of patients if needed.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We saw that the both EDs were visibly clean, tidy and free from clutter at all times during our inspection. In addition, the clean utilities and storage areas were clean and organised. We often saw ED staff working effectively with the domestic staff to complete cleaning tasks.

There were hand hygiene stations in all of the cubicles within the department and wall mounted hand sanitiser dispensers in all corridors and main entrance. We saw all staff used correct hand hygiene techniques after patient care or when moving around the department. We saw staff actively encourage patients, relatives and visiting staff to use the hand sanitisers.

Hand hygiene audits for February 2018 showed compliance ranging from 90% to 100%. Compliance for the infection control module in mandatory training was 94%; these had both improved since the previous inspection. All staff adhered to the ‘arms bare below the elbow’ policy, these included, short sleeves, no watches, jewellery or nail varnish. This was in accordance with the trust’s policy.

Personal protective equipment (PPE), such as gloves, aprons and face protection were available and used as per trust infection prevention and control policy. We saw staff consistently demonstrate the use of effective PPE and dispose of in the correct manner.

Sharps bins (secure boxes for disposing of used needles) in all areas of adults and children’s ED were all dated, clean and not overfilled.

The department had quality safety boards displayed in staff and patient areas highlighting monthly compliance to internal audits for infection control. This was taken from the matron’s dashboard. These also included how many domestic staff were on duty for the shift.

We observed barrier nursing which was compliant to the trust’s infection prevention and control policy. This is a specific set of infection control measures, utilised to minimise the risk of germs spreading to staff or patients.

We spoke with housekeeping staff; whose main role was to assist with the hygiene and cleanliness of the department. They were available 24 hours a day, seven days a week. They spoke of the importance of infection control, and how they contributed to patient safety by ensuring that they followed the infection control policy. We looked at the cleaning stock room and saw that equipment such as coloured mops and buckets, were available and stored correctly. The cleaning chemicals all had appropriate instructions for storage and usage in line with the Control of Substances Hazardous to Health national guidelines.
There were cleaning schedules in place throughout each area, which we saw had been signed at regular points throughout the day, when cleaning was complete.

We saw signs relating to ‘hand-washing’ techniques above all hand-washing basins and there were sufficient supplies of soap, alcohol gel and disposable towels in all the appropriate areas.

There were side rooms in the major’s areas of both the adult and children’s ED, and an isolation room in the resuscitation area. Staff were able to describe the procedure for the use of these rooms and there were visual signs for patients and staff when they were in use for infection prevention reasons.

‘I am clean’ stickers were on all equipment, such as, patient trolleys, monitoring equipment and drip stands, to show that they had been cleaned and were ready for use. Staff told us that each cubicle was cleaned after each patient. We saw this being carried out.

**Environment and equipment**

The environment and equipment were suitable and detailed checks were carried out of resuscitation equipment. There was a compliant mental health assessment room, which had been redesigned following the last inspection.

There was an on-going programme of redesign to the reception, waiting room and triage area to the adults ED. It was recognised in the plan that the improvements should be made to the size, layout and design of these areas to improve patient flow and experience.

During the inspection, we saw that the building works did not interfere with the patient booking in process or triage. The waiting area was adequate and we did not observe any patients standing whilst waiting to be seen.

Reception and triage staff could see all patients in the waiting area; this was the same for the children’s waiting room. Staff in reception sat behind a screened area and had access to panic buttons. Staff were aware of how to raise a security alert and said they felt safe and that security were readily available if needed.

There was a children’s ED, which had a separate entrance off the main ED. It was only accessible through doors with a swipe card. We saw that the access intercom system worked efficiently, and no child or their relatives were left waiting to enter. Only relevant staff had access to the department, other staff had to use the intercom and state who they were.

The children’s ED had a resuscitation room with two fully equipped bay areas. If a further resuscitation bay was needed, there was an area within the adult ED that could be used.

We saw evidence that the resuscitation trolleys in children’s and adults ED were checked and maintained on a daily and weekly basis. Staff highlighted equipment and drugs that needed replacing or were nearing the expiry date.

Equipment had been maintained and current electrical safety testing had been carried out and was clearly labelled. We saw the storage for oxygen and gas cylinders, this was compliant. All gas cylinders were in date.

There were arrangements in place to manage clinical waste and specimens. There was clear segregation of clinical and domestic waste bins, with clear information in what is disposed of in each.
There was a designated room for patients experiencing mental health related illnesses. This room was compliant with the Royal College of Emergency Medicine (RCEM) guidelines. The room had two doors that opened both ways, panic buttons, no ligature points and furniture was weighted so could not be used as a missile. Patients were risk assessed before the use of this room. During our inspection, we saw no patient left unattended whilst in this room.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen. Staff responded appropriately and identified changing risks to people who used the service. Risks to patients were assessed and their safety monitored and managed so they were supported to stay safe. The triage system used was an improvement from the last inspection in 2016. Previously, band 5 staff nurses without experience would triage patients, which we deemed unsafe.

The average time of patient’s initial assessment was less than 15 minutes. There were formalised risk assessments for patient safety, pressure ulcers, falls and venous thromboembolism. Mental health patients were appropriately risk assessed.

All patients who booked into the adult or children’s ED received a full, appropriate triage based upon their presentation. An appropriately qualified registered nurse undertook this 24 hours a day. They used a rapid assessment and prioritisation tool called the Manchester Triage System (MTS) to stream presenting patients through the department. The staff told us the electronic system went above and beyond the observations required by the MTS. The triage system was in line with all Royal College of Emergency Medicine (RCEM) guidance.

Patients self-presenting to ED were seen by a streaming nurse (band 6 or above) after they had booked in with reception. They were streamed to minors, majors, and the resuscitation room or even made appointment with their GP if ED care was not needed.

If a patient was unwell, and needed to start treatment, for example, a patient presenting with sepsis, they could be streamed to the ‘sub-wait’ area of majors. This area had four chairs with observation equipment and was staffed by a nurse and a doctor. Any patient the receptionists were worried about would be escalated immediately to the streaming nurse. However, due to the layout of this area, the nurse could visually see all patients presenting through the front door, therefore reduced the risk of unwell patients going unnoticed whilst waiting to book in.

The new design of the reception, waiting area and triage was going to change to operate a more effective streaming and triage system. The department’s leads visited many other NHS trusts that had been carrying out this model and they told us of the clear plan and strategy for when the building work was done. It would include a consultant being present at the streaming stage, as well as a senior nurse, this would mean that immediate treatment could be started if needed.

We tracked eight patients who self-presented to the adult ED; all were triaged and appropriately ‘streamed’ within 15 minutes. They also had bloods taken and intravenous (IV) cannula’s inserted ready for treatment if needed.

Patients who arrived via ambulance would be triaged by a band 6 nurse and booked in by a dedicated receptionist at the same time. They would be rapidly assessed in a designated cubicle for a full set of observations to be carried out and if needed further tests, such as
electrocardiograms (ECG). Blood tests and IV cannulas were inserted and then they were moved to an appropriate major’s cubicle, or into minors, depending on their presenting complaint.

All major’s cubicles were visible from the main nursing desk situated in majors.

A care bundle was commenced at the start of the patient journey through ED. This contained, a patient safety checklist, safety checklist for transfer of the patient to the ward and risk assessments.

Risk assessments for falls and pressure ulcers were recorded appropriately in all records we looked at. If the patient was admitted to the clinical decisions unit (CDU), then further in-depth risk assessments were carried out. Unless, the patient was in the main ED for longer than six hours, then they would be carried out there.

If the department was very busy, then after the rapid initial assessment, the patient would be moved into an extra capacity area of the department. A registered nurse and an emergency medical technician (EMT) staffed this area, depending on how many patients were there. An EMT was a care support worker, who had undergone extra training in specific ED skills, such as venepuncture and applying plaster casts. They would have one registered nurse per four patients. The maximum patients that would be in the extra capacity area was eight. There would also be a hospital ambulance liaison officer (HALO) in this area, helping offload the patients onto trolleys, carrying out observations and to help deliver flow of ambulance crews back into the community.

We saw evidence of the corridor being used, due to the hospital being at full capacity. This meant ED patients that had been referred to specialties, could not be transferred to the appropriate ward in a timely manner due to no beds being available. However, it was calm and well organised and care and treatment was not delayed whilst they were being cared for in the ED. The corridor was seen as an extension of the major’s department. During our inspection, we saw, due to the prioritisation skills of the nurse in charge, this area had regular flow through and the patients were not in this area for long periods of time before they were moved into one of the main areas of the ED.

The department used the national early warning score (NEWS) and the paediatric early warning score (PEWS) in eh children’s ED. Staff completed these observations in accordance with trust policy, a pain score was included and staff knew the clear escalation process for patients who scored high. However, staff would escalate patients they were worried about even if they did not have a high NEWS or PEWS score.

All observations were electronically inputted in to a handheld device. This communicated with the departments IT system. This showed the NEWS/PEWS for each patient in the department, which was visible by all clinicians and nurses for close monitoring of patients. A sepsis screen was carried out on all patients, if a patient screened positive for sepsis, this would flag on the IT system. We looked at the electronic records for patients that had screened positive for sepsis and the appropriate care bundle and treatment was carried out in line with national guidelines. We saw from local audits, that the rate of compliance for the treatment of sepsis was 98% for March 2018. This meant that patients were receiving their intravenous antibiotics and fluids within one hour of arriving to the department.

The department had trained the band 6 nurses in a patient group direction to administer antibiotics and intravenous fluids used in sepsis management. This meant that as soon as the patient was triaged the treatment could be commenced straight away. Patient group directions allow
healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This guideline aims to ensure that patients have safe and speedy access to the medicines they need, in line with legislation.

There was a designated consultant, who was the named lead for major’s patients and each area had a nurse in charge, patient deterioration would be escalated through to both these leads.

There was an acute physician who would see medically referred patients immediately in the ED, where they could not be admitted to a ward to be seen.

The children’s ED had acute paediatric support for sudden, unexpected deaths in infancy and childhood. The team had debriefing sessions and further counselling provided in these cases if needed.

There were robust clinical stress pathways in place for, resuscitation, trauma, imaging and emergency surgery.

The clinical decision unit (CDU) was used for patients who needed a period of further observation before discharge, or waiting for test results. There was a clear operating procedure for this area and which patients could be admitted to this unit. Each patient that was deemed safe to be admitted to this unit had to be discussed with the lead consultant and nurse in charge.

Staff had access to the rapid assessment, interface and discharge team (RAID) 24 hours a day seven days a week. Staff we spoke with knew how to access this team. They worked alongside the ED staff to enable faster identification of mental health needs among hospital patients of all ages. They were a team of mental health experts offering assessment, diagnosis and treatment for emotional and psychiatric health problems or problems with memory for anyone that attended the ED. The team was provided from the local NHS community partnership trust. They responded within an hour of referral, we saw evidence of this during the inspection.

Emergency Department Survey 2016

The trust’s scored “better than” other trusts for none of the five Emergency Department Survey questions relevant to safety. The trust scored “worse than” other trusts for one question and “about the same” as other trusts for the remaining four 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 emergency department staff?</td>
<td>6.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.2</td>
<td>About the same as 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>8.7</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>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
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 in one month from January 2017 to December 2017. This was October 2017 in which the median time for this rose to 11 minutes compared to the English average of eight minutes.

Ambulance – Time to initial assessment from January 2017 and December 2017 at East and North Hertfordshire NHS Trust

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

Percentage of ambulance journeys with turnaround times over 30 minutes for Lister Hospital

From January 2017 to December 2017, there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Lister Hospital. This percentage was lowest in April 2017 and rose slightly from May 2017 to December 2017.

Ambulance: Number of journeys with turnaround times over 30 minutes - Lister Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Lister Hospital
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 December 2016 to November 2017, the trust reported 562 “black breaches”, with a changeable performance and no general trend over the period. There were peaks in the number of “black breaches” at the trust in February 2017 and September 2017 of 72 and 59 respectively. The lowest number of black breaches in a month was 27, which occurred in June 2017. However, the department had no “black breaches” occur for January and February 2018.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment for the majority of shifts. Nurse staffing levels and skill mix were planned in line with guidance on safe staffing in emergency settings. There were shifts which were short and needed the use of bank and agency.
The trust reported their staffing numbers below for year of 2016/17 and year to date, which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Urgent and Emergency Services</td>
<td>117</td>
<td>186</td>
</tr>
</tbody>
</table>

The fill rate for nursing staff increased from 62.9% in 2016/17 to 90.4% for 2017/18 year to date.

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

At all times throughout our inspection, we found the skill mix of staff to be suitable for the needs of the emergency department. We found that senior staff had oversight of the staff within the department and moved staff around to ensure all areas were safe and to ensure staff breaks were covered.

The emergency department was due to use a combination of the baseline emergency staffing tool and the National Institute of Health and Care Excellence (NICE) emergency department staffing recommendations, to ensure the department was staffed appropriately. This would outline how many registered nurses they needed to safely staff the department. The tools look at the acuity of patients and how many were in the department at certain times of the day. The department had changed some shifts to provide a safe amount of staff at the busiest times of the day. These staffing tools had been used within the last six months.

The nursing handover took place at 7am and 8pm every day. Each nurse handed over their patients to the specific nurse taking over that area and the nurse in charge had a handover of the whole department. This ensured the nurse in charge knew what was happening with each patient and the nurses had a more detailed handover of their care and treatment. There were also safety huddles help throughout the day with the consultant and nurse in charge.

We saw evidence of appropriate handovers from the ambulance staff to the nurses. Staff gave comprehensive handovers when transferring patients to another department within the hospital. The handovers we observed demonstrated effective communication between the staff in the emergency department and other services.

Agency and bank nurses had a detailed hospital and department induction. Most of the agency nurses had worked in the department before, so knew the current practices and processes, and the bank nurses were already employed by the trust. If the department needed to book agency staff, this was done as far in advance as possible.

**Vacancy rates**

From December 2016 to October 2017, the trust reported a vacancy rate of 22.7% in urgent and emergency care for the nursing staff. This was above the trust’s target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
The department recognised the large vacancy rate. They were working with recruitment closely. They had recently employed many newly qualified nurses, and now wanted to attract experience ED nurses. Due to the demographic of the hospital location, managers told us that some nurses were more inclined to work at larger NHS trusts in the capital. However, we spoke with some recently employed nurses who had been students at other trusts and experienced nurses who had worked in other EDs. They found, at the interview stage, this department was their favourite, due to nature of the interview panel and how the trust and department was represented. One new member of staff had a long commute, but did not mind, as they told us they loved working here. The matron explained that recruitment was an ongoing process, but they wanted to recruit the correct, experienced staff. Staffing was recognised on their departmental risk register.

**Turnover rates**
From December 2016 to October 2017, the trust reported a turnover rate of 10.5% in Urgent and Emergency Care this was within the trust target of 12.7%.

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

**Sickness rates**
From December 2016 to October 2017, the trust reported a sickness rate of 3.2% in urgent and emergency care, which is around the same as the trust target of 3.3%.

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

**Bank and agency staff usage**
The trust has reported one of the highest bank and agency staff use to be in urgent and emergency care. The trust is aiming to mitigate this by focusing on recruitment and retention plans.

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

The department used the mainly bank staff, which were their own ED staff undertaking extra shifts. If shifts were unfilled, then the escalation policy stated using nurses from other areas within the hospital. If this happened, the ward nurses would look after the stable patients within the major’s area who were waiting for admission, this then released the ED nurses to look after the high-risk patients who were coming in via ambulances and needed initial assessment and treatment. The use of the ward nurses occurred frequently during the winter months. We were told that they were moved from wards with a low acuity that were well staffed.
Medical staffing

The trust has reported their staffing numbers below for year of 2016/17 and year to date, which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>54</td>
<td>63</td>
</tr>
</tbody>
</table>

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

We spoke with the clinical lead for the departments. They explained that there were no junior doctor gaps in the rota. They worked a 24-hour rota. They explained that this department had gaps in the middle grade rota, similar to other trusts in England. They were using bank locums and locums form outside agencies who had worked in the department previously.

The department’s consultant cover was 14 hours a day, seven days a week. From 10pm, the consultant was on call. There were six middle grades on until midnight, then four middle grades from 10pm until 9am, with six junior doctors overnight.

The Royal College of Emergency Medicine (2010) guidelines recommend that EDs provide 16 hours a day, seven days a week consultant cover.

Medical staffing was on the departments risk register.

The department was training advanced nurse practitioners, who would be able to work autonomously in the ED. This was a mitigating risk many NHS trusts are pursuing, due to the national recruitment concerns for medical staff.

Handovers took place daily at 8am to 8.30am. These were appropriate and efficient. The middle grades also had a handover with the oncoming night shift middle grades.

Vacancy rates
From December 2016 to October 2017, the trust reported a vacancy rate of 9% in urgent and emergency care. This was above the trust’s target of 6%.

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

Staff told us, that even though there is a high vacancy rate in the middle grade rota (this is a national recruitment issue), they explained due to the morale and commitment of the medical team, the rota is safely managed, with the input of bank locum shifts.

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

From December 2016 to October 2017, the trust reported a turnover rate of 21.9% in Urgent and Emergency Care which was worse than the trust target of 12.7%.
Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to October 2017, the trust reported a sickness rate of 0.7% in urgent and emergency care this is better than the trust target of 3.3%.

Bank and locum staff usage
The trust has reported one of the highest bank and locum staff use to be in urgent and emergency care. The trust is aiming to mitigate this by focusing on recruitment.

Staffing skill mix
From 1 October 2017 to 31 October 2017, the proportion of consultant staff reported to be working at the trust were lower the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 38 whole time equivalent staff working in Urgent and Emergency Care at East and North Hertfordshire NHS Trust.

(Source: NHS Digital Workforce Statistics)
**Records**

**Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.**

Staff completed contemporaneous electronic based patient records, which demonstrated clear evidence of care provided and decision-making processes. We reviewed 16 sets of patient records, which detailed clinical history, examination and clinical decision making for each patient. The records showed a clear timeline of care and treatment given within the emergency department.

There was a small paper record generated when the patient was booked in. These were stored appropriately as per trust policy. All paper records we viewed contained appropriate information.

Risk assessments for falls and pressure ulcers were recorded appropriately in all records we looked at. If the patient was admitted to the CDU, then further in-depth risk assessments were carried out. Unless, the patient was in the main ED for longer than six hours, then they would be carried out there.

Mental health, learning disability and dementia needs were all able to be flagged on the patient’s electronic record.

If a patient was transferred to another ward or hospital, they could access the RAID team’s notes. If the RAID team had information regarding the patient, this would be flagged and could avoid unnecessary admissions.

**Medicines**

**The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.**

The trust had medicines policy for healthcare professionals. We saw that the policy was up-to-date with version control and referenced national guidance and legislation.

The clean utility rooms had swipe card access and was well organised with medications including intravenous fluids being stored correctly. Cupboards used to store medicines and fluids were locked and controlled drugs were stored in line with legislation and the trust’s policy.

Staff completed controlled drug reconciliation daily. We checked the stock, which matched reconciliation records, and we could see that the controlled drugs were checked daily without any gap in the records.

Staff correctly completed medicine charts. We reviewed nine prescription records for both adults and children and we saw that the patient’s name, date of birth and allergies documented on the prescription record. The medication doses were appropriate for the patients they had been prescribed for.

Staff checked medicine fridge temperatures daily. We reviewed temperature records for the medicine fridges within the department and saw there were no gaps for January and February 2018 and any concerns had been appropriately escalated.

The department had a designated pharmacist. Their role was to keep on top of stock,
reconciliation, medication errors and looking at prescriptions, antimicrobial stewardship and 
extraditing prescriptions. They would also advise patients and their relatives or carers about 
medications if needed. Out of hours the department had access to an on call pharmacist.

Staff checked patient details before administering medicines. We observed staff administering 
medicines to patients and they asked the patients questions such as name and date of birth to 
ascertain they were administering medicines to the correct patient. Staff practice was in line with 
trust policy.

Out of five drug records we reviewed, all contained patients’ allergy status and patients wearing 
the correct allergy wristband corroborated this. Checks, to ensure that any known allergies or 
sensitivities to medicines, were recorded accurately on patients’ prescription charts within 24 
hours of admission. This information is important to prevent the potential of a medicine being given 
in error and causing harm to a patient.

We saw that drug errors such as missed doses or incorrect doses were recorded as incidents and 
discussed in the department’s monthly meetings. We saw no omissions or errors when looking at 
patient drug records.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported 
them appropriately. Managers investigated incidents and shared lessons learned with the 
whole team and the wider service. When things went wrong, staff apologised and gave 
patients honest information and suitable support.

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

There were clear processes in place for incident reporting, investigation and learning from 
incidents. Staff knew how to report incidents and they were able to give examples of recent 
incidents they had reported. We spoke with six members of staff about incident reporting all of 
these staff members were able to give examples of recent incidents. The staff members varied 
from consultants to healthcare assistants.

Staff reported incidents using an electronic reporting system. All of the staff we spoke with about 
incidents had access to the system and could demonstrate use of the system. The assistant 
director of nursing and the matron for the emergency department had oversight of all incidents that 
were reported within the emergency department.

Learning from incidents was shared through team meetings and discussed at handovers. We saw 
evidence of this.

From November 2016 to October 2017, there were 533 incidents reported to the national reporting 
and learning system. The majority of these, 97, were related with access, admission, transfer and 
discharge category and medicine errors. We were told of a medication error which had been 
shared and practice improved. This was an error which involved the administration of an 
intravenous (IV) medicine. The nurse could reference the action points from the investigation, said 
that duty of candour had been applied and the change was, that no newly qualified nurse could
give IV medicines without completing competencies first.

**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 January 2017 to December 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 17 serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England from January to December 2017.

These were:

- Treatment delay meeting SI criteria with six (35.3% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with six (35.3% of total incidents)
- Slips/trips/falls meeting SI criteria with two (11.8% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (11.8% of total incidents)
- Confidential information leak/information governance breach meeting SI criteria with one (5.9% of total incidents)

All 17 incidents occurred at Lister Hospital.

*(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))*

There was clear evidence that these serious incidents were investigated in detail. Improvements were made and learning shared through departmental meetings, newsletters and daily safety huddles and handovers. We saw evidence of presentations about all serious incidents that occurred in the ED. These were regular presentations given to the staff. They outlined the incident or complaint and all aspects were discussed.

Mortality and morbidity rates were discussed at the department’s clinical governance meetings. Senior staff attended the mortality board meetings, which had representatives from all divisions.

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

We saw evidence from investigations and incident reports, that duty of candour had been applied. Staff knew what duty of candour meant and how it applied to the incident reporting process. From January 2017 to November 2017, the ED had formally applied duty of candour 22
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 no new pressure ulcers, falls with harm or new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

We saw evidence that care was delivered in line with recommended national guidance for emergency departments and medicine. This included specific pathways for patients presenting with head injuries, sepsis, stroke, myocardial infarction (heart attack) and fractured neck of femur.

The department used the ‘sepsis six’ care bundle and active cancer sepsis care bundle pathways in line with the National Institute of Health and Care Excellence (NICE) guidance for adults and children. These pathways were to aid those delivering care with the rapid recognition and treatment of severe sepsis. There were proformas in place for staff to record their actions within defined guidelines and the department were conducting regular audits.

The stroke pathway coordinated communication between the ambulance crews and ED staff prior to arrival. ED staff contacted the stroke consultant and specialist stroke nurse. A specialist stroke nurse was available 24 hours a day, seven days a week. The stroke consultant worked from 8am to 6pm. Outside of these hours the ED doctors used video calls to speak directly to a stroke consultant at other NHS trusts to make a decision to thrombolyse. We saw evidence of this pathway during inspection it worked efficiently. This pathway was in line with NICE guidance, which dictates that adults presenting at an accident and emergency department with suspected stroke were admitted to a specialist acute stroke unit within four hours of arrival. Staff told us that since the 24 hour stroke pathway was implemented it had significantly reduced the time a patient received treatment. They would then be transferred to the specialist stroke unit.

The department met the requirements for units which see less seriously ill or injured as outlined by the RCEM. This guidance refers to units that deliver urgent care services such as treatment for
minor injuries and relates to competencies of healthcare professionals, clear pathways for care and treatment and access to emergency facilities. However, we did see out of date clinical guidelines for the emergency nurse practitioners in the minor’s unit. We raised this with the trust and they were updated. The staff told us, it was because they were experienced practitioners that had worked for the trust for a long period and did not need to reference them anymore and any updated in change of practice was communicated verbally. However, they understood that they needed to be updated for new staff and any changes of practice should be reflected in them.

The children’s ED were using pathways of care for children presenting to ED including abdominal pain and exacerbated asthma in line with the Royal College of Emergency Medicine (RCEM) guidelines.

We spoke with nursing and medical staff who had a good understanding of the Mental Health Act 1983 (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental health concern and if they required treatment for a physical illness, consent would have to be sought in line with current legislation. The rapid assessment, interface discharge (RAID) team would use the Lester cardiometabolic tool. This is a tool to guide health workers to assess the cardiometabolic health of people experiencing psychosis and schizophrenia, enabling staff to deliver safe and effective care to improve the physical health of mentally ill people.

Older people who were frail or vulnerable would be assessed by the frailty team within ED. They would assess all needs including physical, mental and social needs.

We saw evidence during handovers and staff informed us, that they would take into account patients emotional and psychological needs as part of their clinical handover. This would include the patient’s relatives if applicable.

**Nutrition and hydration**

Staff gave patients **enough food and drink to meet their needs and improve their health.** Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

We spoke with housekeeping staff who stated they did offer healthy options to patients. There were water and squash rehydration stations in each area. These could be used by relatives and carers. Patients who were nil by mouth had this marked clearly in their cubicle.

Nursing and support staff carried out hourly checks for patients waiting to be seen and those waiting for admission and offered refreshments when appropriate.

We saw evidence on patients records that fluid and food intake had been monitored effectively when patients had been in the department for over six hours, or were in the clinical decisions unit. The Malnutrition Universal Screening Tool (MUST) was used, which identified adults who were malnourished or at risk of malnutrition.

The staff could access dieticians for support if needed. For example, if patients required parenteral nutrition. This was the feeding of patients intravenously.
Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 7.5 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

Patients pain was assessed and managed using pain assessment tools. Assessment of pain in patients with difficulties communicating was assessed using a specific pain management tool and managed well.

Data from the CQC 2016 accident and emergency survey showed that the department was performing about the same as other trusts in relation to pain relief and control. This is shown in the table below. We reviewed seven sets of patient records and we saw staff had completed pain scores and appropriately administered prescribed analgesia.

The ED had a pain scoring tool which was used to record the patients’ level of pain. Adult patients were asked what their pain score was from 0-10. In the children’s ED, they used a visual pain assessment tool, which was in line with the RCEM guidelines.

For patients living with dementia, or had other communication difficulties, the staff used the Abbey Pain scale. This was recommended by the General Medical Council. This tool looked at the facial expressions, body language, behavioural and physiological changes in the patient. This would be completed hourly until the patient scored for ‘mild pain’, then four hourly.

Patients we spoke to said that they had been asked about their pain and had been given pain relief if required.

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 5.9 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 7.7 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>5.9</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>7.7</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>7.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. The ED measured their performance against the RCEM national clinical audits. However, they did not always meet the standards in line with the England average but did have action plans to deliver improvements.

The RCEM invites emergency departments to take part in national clinical audits annually, which evaluate care based against agreed standards.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17
In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the seven standards.

The trust was in the upper UK quartile for two standards:

- Standard 1a: O2 should be given on arrival to maintain sats 94-98%
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED

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

- Standard 5a: steroids given within one hour of arrival for acute severe asthma, if not already given before arrival to the ED

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

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17
In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the four standards.

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

- Fever in children under 1 year of age
- Abdominal pain in patients aged 70 years and over

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

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17
In the 2016/17 Severe sepsis and septic shock audit, the trust failed to meet any of the eight national standards.

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

- Standard 4: Serum lactate measured: Within one hour of arrival
- Standard 5: Blood cultures obtained: Within one hour of arrival
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival
- Standard 7: Antibiotics administered: Within one hour of arrival

The trust's results for the remaining four metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16
In the 2015/16 Vital signs in children audit, the trust failed to meet any of the audit standards which are all set at 100%.

The trust was in the lower England quartile for one fundamental standard and no developmental standards:

- Standard 1a: All children attending the emergency department with a medical illness should have a set of vital signs consisting of: temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score

The trust’s results for the remaining five metrics were all between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

Since the department had implemented the electronic observation system, with in built escalations, this was set to improve.

RCEM Audit: Procedural sedation in adults 2015/16
In the 2015/16 Procedural sedation in adult’s audit, the trust failed to meet any of the audit standards, which are all set at 100%.

The trust’s results for all seven metrics were between the upper and lower England quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16
The trust did not participate in this audit.

(Source: Royal College of Emergency Medicine)

The department did not have a pathway at the time the RCEM audit was carried out for the VTE audit. However, they have since developed a trust pathway in collaboration with the trauma and orthopaedics team. We saw evidence of staff using the VTE risk in lower limb immobilisation in plaster cast proforma. All the patients that presented with a lower limb fracture had a VTE assessment carried out; they would take the bloods if needed. If it came back as positive, they would highlight this on the electronic records and they would be seen in fracture clinic within 72 hours.

We saw evidence that the department had taken steps to improve their performance in the standards measured in the RCEM audits. These included, a new adult asthma proforma, which
was developed alongside the acute respiratory team. This was currently being used as a trial and being audited. For the consultant sign off audit, all patients are discussed with the consultant or senior registrar before discharge. All plans and reviews of the patient were now recorded on the electronic patient record. This was now a departmental policy and was discussed at all doctors' inductions.

The department now audited sepsis as part of a CQUIN, the commissioning for quality and innovation framework. For February 2018, the audit showed that the ED were screening 96% of their patients for sepsis and 60% were receiving treatment within the time specified in the guidelines. This was the same as other trusts for treatment, and better than other trusts for screening. We were told the ongoing results would be improved, due to the usage of the electronic record system. At the time of the audit, it had not long been implemented and not always used correctly, meaning that the data was not captured correctly.

As an improvement from the RCEM audit, the department had implemented training for band 6 nurses to be able to administer the intravenous antibiotics and fluids, without waiting for a clinician to prescribe. This was in the form of a patient group direction. Staff were positive that this would improve outcomes for patients and would be reflected in the next audit.

Patient electronic records we looked at during the inspection, showed that all standards had been achieved.

Following the results from the post procedural sedation audit, the department felt they needed to update their policy to be in line with the RCEM guidelines and there was also a need for a new procedural proforma. These were in the developmental stages during the inspection, however, we saw evidence of these at the draft stages.

**Unplanned re-attendance rate within 7 days**

From January 2017 to December 2017, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally worse than the England average. The trust submitted no data for September 2017 when a switch to a new patient administration system affected data submission.

(Source: NHS Digital - A&E quality)
There was a specific team for the care and treatment of the frail older patient. This team responded efficiently to referrals and impacted positively on patient flow.

The implementation of the frailty team and discharge coordinators, who worked with the frail and vulnerable older patients, would improve re-attendance rates. Due to the social needs being looked after and plans in place for them in the community. As most of their re-attendances were specific to patients not coping once discharged from hospital.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support. Nursing staff had a competency booklet that had a standardised approach specific to urgent and emergency care nursing. However, nursing staff’s compliance for appraisals was 74%. However, the matron had developed a new way of conducting staff appraisals to improve compliance.

Nursing staff’s compliance with adult immediate life support was only at 73%. However, in the ED, doctors were always present.

The department had systems in place to ensure the professional registration of permanent employees was maintained and up to date. All staff employed within ED and children’s ED were up to date with their registration.

All staff within the children’s ED and children’s assessment unit, worked under the women and children’s directorate. Their training and appraisals were carried out under this division. The staff we spoke with during our inspection told us that they had received an appraisal within the last year and their training needs were met. Staff were given opportunities to develop professionally. For example, four nurses had commenced the course to become advanced nurse practitioners and others had started the non-medical prescriber’s course for minor illnesses. One of the emergency medical technicians told us, they had learnt so much since starting this role. They had a detailed competency booklet and had completed cannulation, phlebotomy, wound care, suturing and plastering. They said they had received ‘marvellous support’ from matron and senior sisters to complete these.

Nursing staff in the adult ED were required to complete adult basic and immediate life support. However, only 73% had completed immediate life support. Senior nurses who worked in the resuscitation area had completed advanced life support. Even though they saw no children in the adult ED, the staff were still expected to complete paediatric basic life support. The junior doctors and consultants that worked within ED had all received basic, immediate and advanced life support.

The nursing staff in the children’s ED had all received paediatric immediate life support and senior nurses and the medical staff had completed advanced paediatric life support.

Unfortunately, the education facilitator within the adults ED had left, this left a gap at present for
one to one teaching and supervision within the department. The matron told us they were mitigating this with specific meetings relating to ad hoc training needs.

Triage training for the senior nursing staff was at 100%. Competencies were assessed in relation to triage assessment. The nurses we spoke with during our inspection had all completed triage training.

The adult ED staff had recently completed the trauma immediate life support course, this had been a success and staff spoke positively about this.

Junior doctors told us that they were given regular teaching sessions by the medical staff, and they were always given opportunities to learn whilst on shift. They had specific simulation days to training in areas of resuscitation and trauma.

Staff who had recently joined the department had an induction booklet to complete and they were given a two weeks supernumerary period. This could be extended if this was needed. We spoke with two new staff members who said the induction booklet was comprehensive and helped them fulfil learning needs specific to ED nursing. This induction was also used for agency nurses who had not worked in the department before.

We saw evidence of the induction booklet and it was detailed and comprehensive. The staff could also access any policy via the trusts intranet.

Staff received dementia training, 30% of staff this year had completed this. We spoke with a member of the nursing team and they told us they had also been invited to complete mental health training, provided by the rapid assessment, interface and discharge (RAID) team. They told us that the junior nurses who had not had received training around mental health were all booked on to this course. The RAID team had also carried out training for the ED nurses in relation to communication and behavioural challenges in mental health patients.

The mental health liaison team and the RAID team all had the relevant qualifications, skills knowledge and training to manage issues arising from patients with mental health conditions, learning disabilities and dementia.

The trust was actively recruiting volunteers. We saw evidence of a poster and this was advertised on the trusts internet, to recruit volunteers to the ED. It asked for volunteers who were good at putting people at ease, and to assist with signposting patients and relatives around the department’s areas, specifically in the early evenings and the weekends.

With joint working with the mental health team, the department had commenced the ‘empathy project’. This was where youth workers volunteered to provide emotional support to patients, they had undergone appropriate training and staff told us that this was working well.

**Appraisal rates**

From April to October 2017, 71.8% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the
table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>93</td>
<td>125</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>24</td>
<td>35</td>
<td>68.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Nursing staff were now allocated to teams, with a senior nurse as the lead. They would be responsible for completing their team member’s appraisals in a timely manner. This meant it was not just up to the matron to carry out all appraisals and could now become compliant with the trust target.

Multidisciplinary working

Staff from different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Medical and nursing staff told us that multidisciplinary team (MDT) working between the nurses and doctors was effective and well established. This also included the emergency medicine technicians (EMT), administrative and senior management teams.

We observed effective communication between nursing and medical teams at their handovers. Staff discussed risks and patient safety including acuity levels of patients. We saw that staff at all levels within both the nursing and medical teams were encouraged to contribute.

We saw evidence that the department had been working closely with external providers and commissioners to improve pathways of care for mental health patients. Staff told us they had developed effective working relationships with external and internal teams.

The department had access to the rapid assessment, interface and discharge (RAID) team. They
were now available 24 hours a day, seven days a week. They saw adult patients presenting with acute mental health concerns. We saw evidence of effective communication between this team and the ED staff during our inspection.

For children presenting with mental health concerns the staff in the children’s ED would contact the children and adolescence mental health team (CAMHS). Staff told us the services were timely and communication and relationships was good with all teams.

We spoke with the clinical navigation nurse and staff from the frailty intervention team. They worked closely with the ED staff to help reduce avoidable admissions by identifying patients that would benefit from care and treatment in the community.

The ED had a dedicated stroke nurse and consultant, we evidence of effective team working relationships, which benefitted the patient receiving timely care and treatment of stroke symptoms.

The ED doctors had close working relationships with the other speciality teams, such as medicine and surgery. This enabled an efficient patient referral process.

We observed the hospitals bed meeting. This is where members form the hospital senior management team liaised with the leads from wards and the ED. We saw evidence of the hospital staff working as a team to benefit the patient and flow in the ED.

During our inspection the deputy general manager was always visible, supporting and working with the nurse in charge and the consultant in charge of the shift. This showed positive multidisciplinary working to improve the flow, and safety of the department for the patients.

**Seven-day services**

Both the adult and children’s ED were operational 24 hours a day, seven days a week.

The department had access to physiotherapy and occupational therapists seven days a week to support those patients that could be discharged.

The department had 24 hour a day, seven days a week access to a dedicated x-ray facility and were supported by their colleagues in the radiology department. This included other diagnostics, such as CT, MRI and ultrasound.

The ED had access to an emergency and trauma theatre as per national guidance 24 hours a day, seven days a week. The ED staff could access their critical care and surgery colleagues in these cases.

A dedicated ED pharmacist and technicians provided pharmacy support. They worked seven days a week, but with reduced hours at the weekend. They were currently submitting a business case to increase the staff establishment, thus increasing cover over the weekends. There was a pharmacist on call if ED staff needed advice or medications out of hours.

The RAID team were available 24 hours a day, seven days a week for adult patients with mental health concerns. Children were referred to the CAMHS team from 9am to 9pm. Outside of these hours, children under 16 years would be referred to the paediatric ward and seen by CAMHS the following morning. Patients who were 16-17 could be referred to the RAID team and assessed in
ED by the nurse and the on call psychiatrist. However, they would not commence any treatment until they could discuss with their CAMHS colleagues.

There was also a drug and alcohol liaison team available Monday to Friday 9am to 5pm. This team was provided by an external provider and no longer provided services at the weekend.

The frailty intervention team were available to ED from 8am to 4pm. Outside of these hours the patients could be assess by a clinical navigator and appropriate social needs could be met if being discharged back to the community. This had been implemented since the last inspection in May 2016 and had made an improvement in services the patients could access.

Health promotion

National priorities to improve the population’s health were supported within the department. in the children’s ED we saw healthy eating posters, such as the amount of sugar present in various drinks and how to choose the healthy option. Posters in children’s and adults ED were changed regularly with new health promotion topics.

We saw evidence of staff asking patients about their smoking and drinking history. We were told there were leaflets available if patients wished to get further information about stopping smoking and reducing their alcohol intake.

People who used the service were empowered and supported to manage their own health, care and wellbeing. For example, staff would give advice and tips in managing cold and flu symptoms at home and explain local pharmacists can treat and advise. This was helpful in the ED, as staff wanted to promote other services and explain that ED was not always the best route of care for non-urgent ailments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We spoke with nursing and medical staff that were able to describe the relevant consent and decision making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in place to protect patients. Patient’s consent was gained as per trust policies.

Staff in the children’s ED were able to demonstrate how Gillick competence related to the consent process and their practice.

The matron completed DoLS assessments, if this was needed out of hours there was an on call matron who would carry these assessments out. We saw evidence of this carried out whilst on inspection, it was an appropriate assessment. The patient was also closely observed by a member of the enhanced care team. They provided one to one observation, called specialling. Staff told us this worked well.

We saw that the trusts MCA policy was kept in the department and was up to date. MCA was part
of the safeguarding training.

If patients were aggressive, they would try and calm the situation with the presence of security. If patients needed more formal restraint or rapid tranquillisation because the patient was at risk of harming themselves or others, then they would be advised by the mental health team and the trusts policies. Security and the ED staff did not have powers of restraint.

**Mental Capacity Act and Deprivation of Liberty training completion**

Mental Capacity and Deprivation of Liberty training was included in level 1 and 2 of safeguarding adults training modules. Staff were compliant in completing this training. All staff we spoke with had a sound knowledge of consent and the Mental Capacity Act.

**Is the service caring?**

**Compassionate care**

Staff cared for patients and those close to them with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patient and those close to them were treated with respect, including when receiving personal care.

Patients we observed and spoke with who used the service felt supported and well-cared for. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.

The staff were kind and had a caring, compassionate attitude. They had positive relationships with people using the service and those close to them. This was an improvement form the last inspection in May 2016.

We observed staff taking the time to interact with patients and their relatives or those close to them.

We observed medical and nursing staff comforting patients appropriately that were distressed.

We spoke with patients and those close to them who stated that staff had been friendly, professional and helpful. They told us that staff respected their individual preferences, culture, faith and background.

They felt that their privacy and dignity was respected and they were treated with courtesy when receiving care. We saw curtains were always drawn in cubicles and doors closed to consulting and triage rooms when care and treatment was taking place.

We observed the play specialist with children in the ED and children's assessment unit. They played, distracted and kept the children calm and entertained. Parents found this helpful, especially when they needed to speak to medical or nursing staff.

We observed staff demonstrate a person-centred approach for patients with additional needs, such as patients living with dementia. One patient was very confused and the nurse was able to
calm the patient by using communication skills and distraction techniques to manage them safely and displayed kindness and patience.

From April 2017 to November 2017, the department scored better than other hospitals in the Friends and Family test when asked if they would recommend the department.

During the inspection we were approached by a member of the public who wanted to share with us the ‘wonderful care’ given whilst in the ED.

**Friends and Family test performance**
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the English average from December 2016 to March 2017. From April to November 2017 it was better than the English average.

A&E Friends and Family Test Performance - East and North Hertfordshire NHS Trust

![Graph showing Friends and Family Test performance]

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Appropriately trained volunteers provided additional emotional support to patients and those close to them. The department had commenced the ‘empathy project’, in which appropriately trained volunteers provided emotional support.

Staff provided emotional support to patients to minimise distress. We observed a member of staff talking to a very anxious patient, as they thought they had lost their belongings. This was making the patient very agitated and distressed. The member of staff was assuring the patient and told them they would find their belongings. Once the member of staff returned the belongings, we saw the patient was pleased and their anxiety was immediately alleviated.

There was a multi faith chaplaincy service available to offer support to staff, patients and those close to them. They provided emotional care provided an outlet to express loss, fear, anger and sorrow. They were also available to respond quickly to the department to support patients who
were dying or to support those close to a patient who had passed away in the department. They were available 24 hours a day, seven days a week.

We were given examples from staff that had needed extra pastoral care. They were supported by the matron and referred for counselling. The staff in the children's ED told us they were supported emotionally when they had been involved in distressing cases. This was done by debrief sessions and further support provided if needed.

For the relatives who had suffered the loss of a child would be supported by the nursing and bereavement team. The staff in the children's ED showed a clear understanding of how to support families and carers after a loss of a child and could explain this process. They worked closely with the bereavement and safeguarding team, having meetings twice a year to discuss further ideas on ow they could support families through the bereavement process.

Staff could direct patients and carers to services that provided counselling and support for people living with different conditions if required.

The department were also supported by volunteers of the 'empathy project'; they were available to provide emotional support to patients and those close to them.

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

Staff involved patients and those close to them in decisions about their care and treatment.

**Patients told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. Staff communicated with patients in a way that they could understand.**

Patients felt they could ask questions if they did were unsure about the information given to them.

Relatives and those close to the patients felt involved. We spoke with a patient’s relative who told us that the doctor had explained the treatment plan and what would be happening next during their time in the ED. This helped alleviate any anxieties the relatives previously had.

Families were involved in the care and treatment plans of children. We saw staff in the children's ED and assessment unit explaining medicines, treatment and further plans of care. Parents told us they were informed and the staff took the time to explain everything, even repeating it if necessary.

We spoke with relatives in the waiting room and they told us they kept informed what was happening to the patient and when they could come through and see them.

We observed staff modifying their language, tone and pace of speech to communicate with patients and those close to them to help them understand their care and treatment.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.
<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>3.9</td>
<td>About the same as 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>8.8</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>8.4</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>9.1</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>8.7</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>9.3</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>7.2</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>8.7</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>7.9</td>
<td>About the same as 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>9.1</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>8.1</td>
<td>About the same as other trusts</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>9.0</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>7.3</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>6.4</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>8.7</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>8.2</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>8.8</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>5.3</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>6.0</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>5.4</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>6.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
--- | --- | ---
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.1 | About the same as other trusts
Q45. Overall... (please circle a number) | 7.8 | About the same as other trusts

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

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Facilities were appropriate to their needs.

Planning for service delivery was made in conjunction with a number of external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external providers to provide GP support in the minor’s department. This was in line with the Royal College of Emergency Medicine guidance on how to achieve safe, sustainable care in emergency departments. The department had the ability to stream patients to the minor’s department, where they could see a GP or nurse practitioner. This was in line with NHS Improvement, Good Practice Guide: improving patient flow 2017.

The department was undergoing changes to the design and layout to the reception, waiting area and triage rooms. This was to improve capacity, flow and allow an effective streaming process.

Both EDs had facilities and premises that were appropriate for the services provided, however in the children’s ED we were told when it was busy it can become cramped in the waiting room. Staff told us, that rearranging some of the furniture and toys could improve this. However, at the time of our inspection there was not a formal plan in place to do this.

Since the last inspection in May 2016, signage around the department had been improved.

The frailty intervention team worked closely with the ED team. This met the needs of the older, frail, vulnerable population. They would be reviewed by a specialist frailty consultant, then a plan of care and decision was made to either admit the patient or discharge home with social input, or to another community service. There was a frailty unit next to the clinical decision unit (CDU). The department recognised that this was a service that the department needed for their community and they used four of the CDU beds to accommodate this service.

The trust worked with the local NHS partnership trust, which provided the rapid assessment, intervention and discharge team (RAID) to increase the hours of the service, to meet the needs of patients with mental health concerns. The RAID was increased from 9am to 9pm, to 24 hours a day, seven days a week. Staff told us this had made a dramatic improvement to patients with mental health concerns, experience and treatment.
Meeting people’s individual needs

The service took account of patients’ individual needs.

Services were generally planned and delivered in a way that took into account the needs of different people such as age, disability, gender, race, religion or belief and sexual orientation.

Patients with complex needs, such as learning disabilities, would be cared for in a cubicle or seated area that was visible to the nursing staff. However, if the patient required a quieter environment, this would be accommodated. The admitting, assessing nurse or clinician would carry out a comprehensive assessment to identify the patients support needs to promote continuity of care and maintain appropriate levels of support during their stay in the ED. They would check if there was a learning disability alert on the electronic system. If there was not they would liaise with the patient’s carers and family to gain consent to place an alert on to it. They would see if the patient had a ‘purple folder’ or health passport to ensure all staff had the patient’s information to utilise.

Staff told us that a learning disability liaison nurse was available to the department Monday to Friday, 9am to 5pm, to support patients, cares and the staff. Patients with learning disabilities would be ‘flagged’ on the electronic system, which meant that the learning disability liaison nurse could identify the patients as soon as they were booked in. Also, bed managers and on call managers could see this information and allocate suitable beds early if the patient was to require admission.

Staff we spoke with had an understanding of how to care for patients living with dementia. They used blue flower stickers and yellow wristbands for patients living with dementia. We saw these in place during our inspection. In the clinical decisions unit (CDU) the blue flower was used in each of the whiteboards in the bays. Staff used the ‘this is me’ pathway, this helped staff make reasonable adjustments to the environment and the care delivered. Staff said it helped the patients feel ‘more relaxed’. They also identified on the whiteboards if patients had any dietary requirements, risk of falls and any communication needs. Twiddle muffs were available for patient living with dementia. These were knitted woollen sleeves with buttons and ribbons attached; research had shown that these reduce anxiety in patients living with dementia.

Frailty was identified and measured on arrival. The patient would then be referred to the frailty intervention team and could be transferred to the frailty unit if needed. This was an improvement to the service since the last inspection in 2016. And showed evidence how they meet individual patient needs in relation to age.

A telephone translation service could be accessed for patients who were unable to communicate in English. A flow chart was visible in the department to advise staff on how to access the translation services. There were also services staff could contact if patients were deaf, deaf-blind or hard of hearing.

There were a range of leaflets relating to illnesses and injury advice. These could be printed off in other languages if needed. There was a bereavement file that contained information and advice in what steps and arrangements to take following a death. All leaflets within this folder were available in a range of languages.
In the children’s ED, there were a variety of information leaflets and posters. These ranged from injury advice, bereavement support and accident avoidance. There was a room designated ‘baby feeding’, this ensured families had privacy when breast feeding their children.

There was a designated play specialist for the children’s ED and assessment unit. They used a range of distraction and educational play activities. There were toys and colourful pictures on the walls and ceilings.

There were private rooms for relatives and those accompanying acutely unwell patients to discuss sensitive situations in both the adult and children’s EDs.

There was a CDU to allow periods of observation, investigation and treatment prior to discharge. This was led and supervised by a consultant and matron. This was in line with NHS improvement guidelines.

The relevant mental health teams, such as the children and adolescence mental health team, community mental health and learning disability teams would get copied into any relevant discharge correspondence.

There was water and squash available in all areas within both EDs and a small coffee shop in the waiting area of the adults ED. Patients that were not nil by mouth were given jugs of water and hot food if required. There were sandwiches and soup available outside of the designated meal times.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all questions in the Emergency Department Survey 2016 for the responsive key question.

<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>6.9</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>7.3</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>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Access and flow

People could access the service when they needed it. Waiting times between four hours and 12 hours from their decision to admit was better than the England average.

From January 2017 to December 2017, no patients waited longer than 12 hours after the decision to admit to being admitted.

Nursing staff worked collaboratively with senior management and the operations team to facilitate flow through the department.

There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital. The operations control room and bed team could see on the IT system the length of time patients had been in the ED, who had been referred and required admission.
The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. This was all discussed at regular bed meetings throughout the day and plans made. The deputy general manager worked closely with the nurse in charge of the department to facilitate communication to the operations team. We saw evidence of this during our inspection. they were always in the department trying to improve flow in busy times.

There were often of overcrowding; this is when ambulance crews cannot offload the patient into the major’s area. The corridor was used as extra capacity, they would offload up to eight patients in this area and were looked after by one or two registered nurses, depending on how many patients were cohorted here and an emergency medical technician. Once there were eight patients in this area, the full capacity protocol was implemented. During the inspection this area was used, however patients were not in this area long. Whilst they were in this area, they were seen treated and cared for appropriately and moved to a cubicle in a timely manner.

Clinically stable patients that had been referred via their GP for medical or surgical reviews would be seen on the appropriate assessment areas if the hospital had capacity. If the assessment areas were full, the specialist doctors would have to see them in the ED, this happened in a timely manner. However, this impacted on the EDs capacity and the incoming ambulances that needed offloading. We were told during the winter months that this would occur more frequently.

From the data below, it shows that the department were not meeting the Department of Health’s target that 95% of patients should be seen and discharged or admitted within four hours. We spoke with senior management and the clinical lead regarding this target. They explained that ED attendances currently exceeded the average number of discharges from the hospital between 7am and 7pm. This then created an ‘exit block’ in the ED, further increasing the department’s occupancy; this in turn increased the risk of overcrowding in the corridor. All patients we saw during our inspection were safe and cared for. However, staff did not like having to care for their patients in the corridor, and we were told when the hospital has capacity and there was flow, the ED ran efficiently and effectively.

The clinical lead and the directorate managers told us that they were changing the culture of the four hour target being just the responsibility of the ED, and that the whole hospital had to be involved in able for the ED to meet it. They were rolling out ‘midnight huddles’ for all specialty doctors and on call managers to meet and support ED if overcrowded, initiate early discharges on the ward and ensure that referred patients were seen in a timely manner.

We were told that when the managers looked at the reasons for any patient breaching the four hour target, the majority were due to lack of capacity within the hospital, not due to patients waiting to be seen or receive treatment in the ED.

There was an ambulatory emergency care (AEC) unit. The streaming nurse could access this. If the AEC was full, the nurse from that unit would come to the ED to see patients that would be suitable and start the treatment and admission process.

The streaming and triage nurses would assess if patients were ‘fit to sit’ to wait for treatment. This was in line with NHS Improvement guidelines.

A GP worked in the department, specifically in the minor injuries/urgent care unit in the adult ED. Patients could be seen by the GP which reduced the demand on the main department.
Patients who were waiting for admission to the hospital were managed appropriately. Medication charts were written up, so they could receive their regular medicines, risk assessments were carried out and food and drink would be given. Patient’s would be transferred onto a hospital bed if they were in the department longer that six hours, unless they were high risk for pressure ulcers then this would be transferred onto the relevant pressure relieving equipment as soon as possible.

Patients referred to the RAID and CAMHS teams were seen in a timely manner. The RAID team would respond within the hour if CAMHS could not assess the child in a timely manner. They would be transferred to the children’s assessment area or paediatric ward for observation until they arrived.

There was an escalation plan that the nurse in charge and the general manager would implement, to raise staffing and capacity issues. The escalation levels would be discussed during the operations meetings, which occurred four times a day. All senior staff and matrons had a good knowledge of the escalation procedures and we saw this carried out during our inspection. When the corridor was being used for extra capacity, this had always been escalated to the general and deputy manager’s in a timely manner and actions were out in place to ease the pressure in ED and allow ambulance to be offloaded.

Within CDU there were clinical navigators who were either occupational therapist or physiotherapists. They carried out mobility and social assessments of patients and facilitated timely discharge where appropriate. This service ran seven days a week, 7am to 7pm.

The frailty intervention team would assess patients in the main ED. They would assess frail older patients brought in by ambulance or self-presented. They were referred quickly by the ED team to be assessed by a specialist consultant led multidisciplinary by seeing these patients as soon as they arrived into the ED, the team could make early interventions that would allow someone to go back home rather than being admitted.

The ED had a designated CT scanner and x-ray was next to the department. This made it easy for patients to access. The children’s ED had its own x-ray department.

**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 from January to August 2017. The trust moved to a new patient administration system in September 2017, which has affected data submission for this metric since then.
Ambulance – Time to treatment from January 2017 to December 2017 at East and North Hertfordshire NHS Trust

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

The service did not meet the national standard for all patients to be seen, treated, discharged or admitted within four hours. Not all trusts were meeting this target and they were slightly below the England average.

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 ED.

The trust did not meet the standard from January 2017 to December 2017.

From January 2017 to December 2017, performance against this metric showed a trend of slight decline. There is an anomaly in the trust’s performance for September 2017, which was caused by the trust being unable to submit data when changing to a new patient administration system.

Four hour target performance - East and North Hertfordshire NHS Trust
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From January 2017 to December 2017 East and North Hertfordshire NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average.

Performance against this metric showed a trend of decline over the period. From January 2017 to September 2017 no patients waited more than four hours. In November 2017 the proportion of patients waiting between four and 12 hours was approximately 10% which was the peak for the year.

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

Over the 12 months from January 2017 and December 2017, no patients waited more than 12 hours from the decision to admit until being admitted.

<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>Jan-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Oct-17 | 139 | 0
Nov-17 | 213 | 0
Dec-17 | 291 | 0

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

For January to February 2018, there had been zero 12 hours trolley waits.

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

From January to December 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was variable in comparison to the England average.

From January to August 2017 the trust's performance in this median was stable though rose slowly and was below the national average. In November 2017 it rose to 8.3% but in December 2017 it fell to level similar to the national average. There is an anomaly in the trust’s performance for September 2017 which was caused by the trust being unable to submit data when changing to a new patient administration system.

Percentage of patient that left the trust without being seen - East and North Hertfordshire NHS Trust

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

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

From January 2017 to December 2017 the trust’s monthly median total time in A&E for all patients was similar to the England average. There is an anomaly in the trust’s performance for September 2017 which was caused by the trust being unable to submit data when changing to a new patient administration system.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However, complaints were not consistently responded to in a timely manner.

Complaints would be managed by the matrons of the department. If further support was needed, this was provided by the head of nursing and complaints team. All formal complaints would be sent to the general and deputy managers, divisional directors and consultants if it was medically related. There was a clear, up to date complaints policy in place.

There was clear guidance on display in the ED for those using the service to make a complaint or express their concerns. There were leaflets for the patient advice and liaison service (PALS), they could also access PALS at the main entrance of the hospital if needed.

Complaints would be discussed at monthly and quarterly quality risk committee, clinical governance meetings, and the emergency medicine divisional meetings and locally in the ‘team time’ meetings. If there was an urgent update or change on care or treatment this would be communicated at each nursing and medical handover if needed. Through these methods, all members of the team had feedback on complaints, not just those who were involved. We saw evidence of shared learning from the meeting minutes and talking to staff. Complements were also shared and displayed on whiteboard within both departments.

A change that has made an impact and improvement on patient care and treatment arising from a complaint was the extra sepsis training for staff in the department. Now nursing staff are able to
give antibiotics to patients presenting with sepsis as soon as they arrive and the screening shows positive for sepsis.

Patient feedback was also actively encouraged via social media. Staff told us they would also try and resolve concerns or issues ‘on the spot’. Staff said that in the majority of cases this helped and would not lead to formal complaints. If they could not alleviate the concerns at the time, they would refer them to PALS. PALS was available from 9am to 4pm and would be given the information if it was outside of these hours.

**Summary of complaints**

From November 2016 to November 2017, there were 141 complaints about urgent and emergency care services, the third highest across the trust. The trust took an average of 37.9 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed in 30 days.

Complaint breakdown by site:

- Lister Hospital: There were 118 complaints, which took an average of 39.3 days to complete and close.

Complaints were most commonly related to treatment received and communication.

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

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The urgent and emergency care directorate was overall managed by the medicine division. Urgent and emergency care services for children, provided in the children’s ED and children’s assessment unit (CAU), was managed by the women and children’s division.

Urgent and emergency care services for adults and children were managed by different teams and each had different operational and clinical leads. However, they worked closely together and we saw evidence of this during our inspection. The children’s ED was very busy and the children’s ED matron came and liaised with the main ED matron and consultant. They worked as a team to provide an extra doctor to go and see patients in the children’s ED. This showed effective leadership and management of flow to benefit the patients.

Each division was led by a divisional chair, divisional director and head of nursing. Then there were general and deputy general managers who were operational within the departments when needed. Each ED had matron and a clinical director. The adults ED had recently recruited a second matron, who commenced employment in February 2018. This meant that the matrons
could split workload and each take the lead for different areas. For example, one would lead on majors, resuscitation, streaming/triage and frailty patients. The other would lead on the urgent care unit at QEII and minor’s department in ED, this would include being visible at the urgent care unit throughout the week. They would both oversee the clinical decisions unit (CDU) and complaints.

A matron and a clinical director, who also was the lead for the paediatric ward, led urgent and emergency care for children.

Staff told us that the leaders of this service were visible and approachable. We saw evidence of the general and deputy managers in the department supporting staff throughout our inspection. The matron would also work clinical shifts and were seen to be providing support to staff during our inspection. Staff told us this was normal practice. They also had access to the senior management team to raise any concerns. Band 7 sisters had been rostered to work night shifts to improve clinical leadership on these shifts.

At times when the both services experienced high volumes of attendances, staff told us that leaders were visible and worked as part of the team to maintain patient flow. We observed this practice during our inspection. We were told that this was an improvement since the last inspection in May 2016. The matron had an ‘open door’ policy and the staffs concerns or ideas for change were listened to.

From talking to the leadership team of both EDs, we could see that they were established and an experienced team, who were aware of the present and future social and economic challenges related to delivering safe quality patient care whilst delivering the strategic plan.

The matron told us they were supported by the head of nursing and the general managers and all worked closely together to achieve the aims and objectives of delivering safe, effective and quality care within the ED.

The matron and head of nursing told us they were developing the band 7 sisters. This would give them more responsibility and confidence in managing the department. They had arranged band 7 ‘away days’, given ownership of projects and management time to complete staff’s appraisals and audits.

During our interviews with the leader of the department, they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service.

The matrons were the leads for mental health within the service. However, the care and provision of mental health patients would be shared throughout the medical and nursing teams, supported by the rapid assessment, intervention and discharge team.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and key groups representing the local community.

The trust had a clear vision and set of values. Quality and sustainability were set as top priorities. Both EDs were included in these. The EDs had a vision for what it wanted to
Staff were able to speak to us about the vision and values for the trust. They felt that the vision was clear and put the patient first. The vision and values were discussed at staff’s appraisals, so they understood how they could play a part in achieving and representing the values.

We saw the strategic plan for the medicine and women and children’s divisions, which included the EDs. These had a set of realistic objectives for the future growth and sustainability of the departments. Including continued performance against clinical indicators despite increasing levels of activity, redesign of the reception, waiting and streaming area in adults ED, which had started and was due for completion in April 2018. Also outlined for the adults ED was, to provide an ambulatory care service for all patients referred to a speciality to avoid unnecessary admission into the hospital and implementation of primary care streaming. Staff we spoke with knew and understood the strategy and future plans for the department.

Nursing and medical staff were all consulted on the redesign project and could have input. The clinical director and general manager visited other EDs to see different models and layouts of the reception, waiting and streaming/triage areas. They could then see what would work for their department.

The senior management team were working with system partners including the local ambulance trusts to provide alternative options to the ED.

Progress against the strategy was monitored and reviewed, with updates disseminated via departmental meetings. Progress was fed through to executive level through divisional meetings and clinical governance committees.

**Culture**

*Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.*

We found the culture of both ED departments to be open and inclusive. Staff we spoke with felt that they were valued and respected by their peers and leaders. They enjoyed working for the trust and were proud to work in the adult and children’s ED.

The matrons and band 7 sisters of both EDs had a clear passion and enthusiasm for emergency nursing and their departments. This helped morale to be high amongst the nursing staff and effective team working was evident.

There was a consensus that morale tended to be lower during the winter pressure months due to increased activity within the department. Staff said to combat this; they would see each other socially and go for ‘team breakfasts’ after night shifts. The leaders told us this improved the relationships and well-being of the staff.

Staff felt they were able to raise any concerns, issues and report incidents. The departments dedicated newsletter highlighted improvements and changes made through learning from complaints and incidents and provided information to support the health and well-being of staff.

Staff at all levels told us that although achieving targets was important they were not afraid of
breaching a target if it meant that the patients was safe and received the correct care including admission to an appropriate speciality.

The clinical director for the service told us that they were trying to change the culture of the ED national targets. As the department needed the support and help from the other hospital specialities to achieve them. The reasons for the department not meeting the ED targets were that the hospital did not have capacity. The ED staff had processes and procedures to facilitate flow through their department and told us they would work efficiently and could function as a normal ED, if they were not also a ‘ward’, caring for patients that should be being cared for in the appropriate wards. They told us that this was a work in progress, but other services across the hospital were responding to this change. One example was, at night, each speciality doctor, on call manager and the ED clinician would have huddles, to discuss the pressures on ED and what they could do to help and facilitate flow back to the ED, to ensure patients were being cared for in the correct department. They would discuss the speciality referrals and if any patient was waiting in the ED for a review, they would be prioritised.

The clinical director said they wanted ‘the patient to be the responsibility of the whole trust, not just a patient of the emergency department’.

The nurses were in teams, with a band 7 sister as the team leader. Their role was to undertake the nurse’s appraisals. Appraisals included career development progression and learning opportunities.

There were appropriate security measures in place to keep both staff and patients safe. The department had access to the security team 24 hours a day, seven days a week.

There was a duty of candour policy and staff received training. Staff we spoke with felt identifying when something went wrong could help them to improve patient safety.

The trust was launching international recruitment campaigns to increase workforce diversity.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were governance structures, processes and systems in place for both EDs. There were monthly clinical governance meetings held, chaired by the clinical director. All levels of staff were invited to attend. We saw that incidents, complaints, audits and overall performance was discussed. If staff could not attend, key information would be emailed or shared in the department’s newsletter and also discussed at handover.

We found all levels of governance and management interacted with each other to support the delivery of strategic objectives, such as the redesign of the reception, waiting area and streaming/triage areas. All staff were consulted with and risk assessments developed with all leaders, matrons and clinical director. Information such as strategic objectives would be discussed at local level, and then taken up through the divisional board meeting, clinical governance meetings and quality assurance, then to the trust board.
Staff at all levels were clear about their roles and what they were accountable for and who their immediate line managers were.

We saw arrangements were in place with third parties, for example, service level agreements and acceptance criteria were clearly outlined with ambulance services. These stated which patients could be taken to the hospital and which needed transfer to a different service or hospital. Such as, trauma patients would be taken to a major trauma centre and patients with a myocardial infarction (heart attack) would be taken to the cardiac catheter department, which was situated next to the ED.

There were sepsis leads within the department and the hospital. They would take the lead on sepsis audit and training, with the support from the clinical director.

Once the redesign of the ED was completed, a GP streaming service would be implemented. The standard operating procedures and staffing resources had been completed in anticipation of the completion date. There were joint governance arrangements in place to monitor the effectiveness of this service.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Arrangements for managing and recording risks were detailed. There was a holistic understanding of performance, which integrated the needs of other areas in the trust and the needs of the community whilst focusing on patient safety and quality improvements within the departments.

The department had a specific risk register for the service. There were 13 risks highlighted on the register. The top three risks for the EDs were, staffing levels, overcrowding and IT issues relating to the new system implemented. These risks were also reflected in the board assurance framework and corporate risk register. It was clear who had responsibility for each risk and action plans were in place and being monitored.

The risks present on the register reflected the views of the staff we spoke to at all levels. These were communicated to staff via the newsletter.

The department had a clear annual plan for internal audits and continuously improving in key areas such as sepsis treatment and managing moderate and severe asthma. The audit results would be escalated to the executive board via the department’s performance report being discussed at the divisional meeting, and then fed up through clinical governance, divisional board, then the trust board meetings.

The matron’s dashboard was used to measure and monitor quality and safety performance on a monthly basis and was used in the clinical governance meetings. This included items such as, hand hygiene, infection control, and record and risk assessment audits.
Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service collected, managed, analysed and used information well to support its activities. We saw electronic systems to be secure. For example, the computer screens could not be viewed by other people in the area, due to a special screen, only allowing the user to view the screen.

Information technology systems were used effectively to monitor and improve the quality of care. The introduction of electronic observations was implemented in September 2017. This enabled digital recording of patient observations against the national early warning scores and real time escalation of the deteriorating patient. It also supported clinical care, for example ‘flagging’ patients that were experiencing sepsis. However, there had been some issues with the system when it was first implemented in September. Staff said that it was now an effective system that enabled them to efficiently assess patients using thorough processes and assessments.

We spoke with the divisional chair and director; they were planning to use the electronic system to improve the way the ED clinicians refer to other speciality teams. This would reduce the risk of spending periods on the phone to refer.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Patient feedback was sought by staff and comments shared amongst the team. This was carried out by the Friends and Family Test, also staff actively monitored the NHS Choices website where patients and their representatives could leave feedback, as well as other social media sites. All feedback, whether positive or negative, would be shared with the team.

We saw that there was a communications board displayed in both EDs. This gave information on the Friends and Family test, which showed 90% of patients, would recommend the department for February 2018.

The trust had developed a patient and carer experience strategy. This set out how staff, patients, families, carers and stakeholder groups could all work together to ensure their patients had the best possible experience whilst using their services.

Staff were involved in the planning and delivery of services. Staff we spoke to had been asked and some were actively involved in the planning of the redesign of the reception, waiting area and triage/streaming rooms. With the introduction of ‘team time’ meetings and the dedicated ED newsletter, staff felt involved in the changes that were implanted and had a say.

The clinical director was part of a nationwide communication group, where all clinical directors from each ED across England were part of. This showed active engagement, communication and shared learning between clinical leaders.
Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The new streaming model that was planned and working with external providers, was developed to have a positive impact on reducing avoidable admissions and with continuous monitoring and feedback at all levels involved, new pathways had been developed and continuous learning was still ongoing during our inspection.

The junior doctors had an education programme within the ED that other trusts were approaching them for advice and using their model.

The leaders of the service told us that there had been many improvements they were proud of, especially since the last inspection. These included the frailty intervention team, patients could access this team at any point during their journey, it was patient centered, improved flow, and most importantly it improved the patients care. The department now had 24 hours a day, seven days a week access to the mental health team, provided by the rapid assessment, intervention and discharge team, and an agreement that the ED patients would be seen within an hour of referral. The further training of nurses to become advanced nurse practitioner would benefit the department and they were to be added to the doctor’s rota.
Medical care (including older people’s care)

Facts and data about this service

There are 354 medical inpatient beds and 16 chairs located across 21 wards across East and North Hertfordshire Trust

A site breakdown can be found below:
- Lister Hospital: 320 beds and 14 chairs within 16 wards

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 37,037 medical admissions from September 2016 to August 2017. Emergency admissions accounted for 17,351 (46.8%), 2,717 (7.3%) were elective, and the remaining 16,969 (45.8%) were day case.

Admissions for the top three medical specialties were:
- General Medicine
- Gastroenterology
- Cardiology

(Source: Hospital Episode Statistics)

Medical care services are managed in the division of medicine and emergency care. The last CQC inspection of the medical care service at the Lister Hospital was in October 2015 when the service was rated as requires improvement overall. We carried out an unannounced inspection from 20 March to 22 March 2018 during which we visited 16 wards, the discharge lounge, endoscopy and the cardiac catheter laboratory. The wards visited were:

- Acute Medicine: Acute medicine assessment unit (AMU) assessment, AMU Blue and AMU Green, ambulatory care, short stay unit (SSU)
- 9A and B (elderly care and frailty)
- Barley (stroke)
- Pirton (stroke)
- 6A and B (renal)
- 10B (diabetes and endocrinology)
- 11A (respiratory)
- 7AN (extra capacity)
- 8A (gastroenterology)
- Acute Cardiac Unit (ACU) - cardiology
- Ashwell (elderly care and frailty)
We spoke with 14 patients and relatives, and 41 members of staff, including ward managers, matrons, consultants, junior doctors, staff nurses, specialist nurses, therapists, care support workers, and ward clerks. We looked at 39 sets of patient records. We attended nursing and medical handovers and multidisciplinary team (MDT) meetings. We observed three meal service sessions. We also reviewed data provided by the trust.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

All staff completed core mandatory training on commencement to their post. Subjects were then updated according to guidance. For example, moving and handling training required a two yearly update.

Staff reported that mandatory training sessions were completed as a block of training which lasted half a day or a full day and that training topics were repeated annually or at two year intervals according to the policy. Staff informed us they were alerted through the e-rostering system if mandatory training was due for completion. A training reminder was given to staff members four months before their next pay increment was due. Training was then discussed during their appraisal and if all training was completed this was put towards them receiving their next increment in salary.

Several ward managers told us that there were systems in place which highlighted staff that were due for training updates. We saw that such processes enabled ward managers to have an oversight of training compliance and that managers took action to address training compliance issues quickly. However, despite these measures being in place, there were some aspects of mandatory training that had not reached the trust target.

Some staff members informed us that they were sometimes unable to attend mandatory training due to staff capacity issues.

**Mandatory training completion rates**

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

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

A breakdown of compliance for mandatory courses from April to October 2017 for medical/dental and nursing staff in medicine is shown below:
This is trust wide data for the medicine division across all sites. The trust’s overall medical staff mandatory training completion rate was 63.3%. Of the seven mandatory training courses delivered by the trust to medical and dental staff, none met the completion rate target of 90%. Medical staff told us that it was difficult to be released in order to attend training and that this was the reason for reduced compliance.

We requested updated training figures during our inspection specific to medical staff at the Lister hospital site and the trust sent us the following data for February 2018:

Medical staffing mandatory training compliance Lister hospital site:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>164</td>
<td>192</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 years</td>
<td>164</td>
<td>192</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>164</td>
<td>192</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>164</td>
<td>192</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>150</td>
<td>252</td>
<td>59.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>133</td>
<td>252</td>
<td>52.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>86</td>
<td>252</td>
<td>34.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
This local updated data showed improved compliance with mandatory training for medical staff, with an overall compliance completion rate of 76%. This was, however, still short of the trust target of 90% for training compliance.

**Nursing Staff**

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention &amp; Control-Non-Clinical (including management of inoculation injuries &amp; hand hygiene) - 2 Years</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Moving and Handling - 2 Years</td>
<td>564</td>
<td>584</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>562</td>
<td>584</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>559</td>
<td>584</td>
<td>95.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>556</td>
<td>582</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>485</td>
<td>534</td>
<td>90.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>495</td>
<td>584</td>
<td>84.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>492</td>
<td>584</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>453</td>
<td>584</td>
<td>77.6%</td>
<td>90%</td>
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</tbody>
</table>

This is trust wide data for the medicine division across all sites. The trust’s overall nursing mandatory training completion rate was 90.2%. Of the nine mandatory training courses delivered by the trust to nursing and midwifery staff, six met the completion rate target of 90%.

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

We requested updated training figures during our inspection specific to nursing staff at the Lister hospital site and the trust sent us the following data for February 2018:
## Nursing staffing mandatory training compliance Lister hospital site:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>412</td>
<td>429</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>406</td>
<td>429</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>403</td>
<td>429</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (incl. management of inoculation injuries &amp; hand hygiene) 2 years</td>
<td>401</td>
<td>427</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>337</td>
<td>382</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>377</td>
<td>429</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>366</td>
<td>429</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>347</td>
<td>429</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

This local updated data shows an overall compliance completion rate of 90%, which meets the trust target of 90% for training compliance.

Data for basic life support training was provided separately by the trust on request. We requested training compliance data broken down by staff group specific to the Lister hospital site, for the medicine division, and received the following data:

- Medical and dental staff 58.56% compliant with basic life support training
- Nursing and midwifery staff 81.77% compliant with basic life support training

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.**

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary.
Staff took a proactive approach to safeguarding and focussed on early identification. The service had steps in place to prevent abuse or discrimination that might cause avoidable harm and responded appropriately to any signs of allegations of abuse and worked effectively with others.

Nursing staff told us they were aware of their responsibilities regarding safeguarding and demonstrated how they were able to access the trust policy contained within the knowledge centre (the trust’s electronic learning and development tool) on the intranet. Staff were aware that there was a safeguarding lead within the trust and told us they knew how to contact them for advice. Nursing staff and care support workers (CSWs) were able to describe what situations would raise their concern. Staff could explain the process for raising concerns and were able to describe examples of when they had made safeguarding referrals.

We saw safeguarding posters on display outside all ward areas outlining contact details for raising safeguarding concerns.

Safeguarding training completion rates

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

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

Medical/Dental Staff

A breakdown of compliance for safeguarding courses from April to October 2017 for medical/dental staff in medicine across all sites is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target (%)</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>135</td>
<td>252</td>
<td>53.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>131</td>
<td>247</td>
<td>53.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>131</td>
<td>247</td>
<td>53.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>133</td>
<td>252</td>
<td>52.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall medical safeguarding training completion rate was 53.1%. The trust did not meet the completion rate target for medical staff for any of the safeguarding modules it delivered.

We requested updated safeguarding training figures during our inspection specific to medical staff at the Lister hospital site and the trust sent us the following data for February 2018:
The safeguarding training completion rate for medical staff at Lister hospital within the medicine division was 71%. The trust did not meet the completion rate target of 90% for medical staff at Lister hospital for any of the safeguarding modules it delivered. We requested an action plan from the trust to address medical staff safeguarding training compliance which they provided. The plan involved monthly review of compliance and taking individual actions with staff members as required. The plan aimed to address the compliance issues by May 2018.

**Nursing Staff**

A breakdown of compliance for safeguarding courses from April to October 2017 for nursing staff in medicine across all sites is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>562</td>
<td>584</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>550</td>
<td>572</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>558</td>
<td>584</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>545</td>
<td>572</td>
<td>95.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s overall nursing safeguarding training completion rate was 95.8%. The trust met the completion rate target for all four of the safeguarding modules it delivered.

We requested updated safeguarding training compliance figures during our inspection specific to nursing staff at the Lister hospital site and the trust sent us the following data for February 2018:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>395</td>
<td>416</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>395</td>
<td>416</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>407</td>
<td>429</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>406</td>
<td>429</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The safeguarding training completion rate for nursing staff at Lister hospital within the medicine division was 95%. The trust met the completion rate target for medical staff at Lister hospital for all of the safeguarding modules it delivered.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection including:

- Display of posters to encourage staff and visitors to sanitise their hands on entering wards.
- Hand hygiene information was displayed on wards and in corridors.
- Hand sanitiser was available at the entrance to each clinical area.

On ward 9A we saw that there was a hand gel pump at the end of each bed and a poster displayed on each patient locker prompting staff and visitors to sanitise their hands.

During the inspection we observed a range of staff including nurses, care support workers and ward hostess staff using hand sanitisation gel when entering a bay and before each new patient contact. We observed that most staff worked in accordance with best practice for infection control. This included good hand hygiene, wearing appropriate personal protective equipment (PPE) and being ‘bare below the elbows’ when delivering patient care. However, on the short stay unit during a 15 minutes observation period we saw that a group of doctors on a ward round did not wash or gel their hands between patients and two occasions where nursing staff did not use hand hygiene techniques. A ward manager told us some staff did not always tie long hair up accordingly and we observed two occasions where staff members had long ponytails. This was not in line with the trust’s dress code policy which stated staff must have their hair styled completely off their collar and face and long pony tails were not acceptable. On ward 7A we observed one incident during a
mealtime when a staff member was serving food with a towel over their shoulder which they were using to wipe their own face during the meal service. The staff member told us they did this as they were hot and sweating. We felt that this was not in line with good infection control practise and asked the individual to remove the towel from their person.

Managers displayed compliance with hand hygiene audits on boards outside the ward entrance. During our inspection we saw that audit results displayed, showed compliance of between 79.7% and 100% (average 91.1%) which was not in line with the trust target of 95%. We requested results of hand hygiene audits across the medicine division and in February 2018 and March 2018 compliance was 97.74% and 96.98% respectively. This met the trust compliance target of 95%. We were told that these audits were completed by ward managers. However, the trust also provided the results of the infection prevention and control teams last hand hygiene audits on the medical wards in May and July 2017. These audits showed a much-reduced compliance with hand hygiene audits of between 42% and 83% which was below the trusts 95% compliance target.

Environment and cleanliness audits were completed monthly and results displayed on ward boards. During inspection we saw cleaning audit scores displayed of between 93.78% and 98% where the average score was 95.68%. This was within the trusts target for cleaning audit results. The nursing and quality indicators for February 2018 showed that out of 13 ward areas, eight met the trust target of 95%; one ward did not provide any data and the remaining four scored below the trust target of 95%. We noted that in February 2018 Ashwell scored 98% for ward cleanliness in February 2018, AMU Green scored 93% for ward cleanliness and ward 7A scored 92% for ward cleanliness.

Cleaning services on the ward were provided by an external contractor. We observed a positive interaction between domestic staff and ward staff. We saw a daily and weekly monthly cleaning schedule displayed outside most wards. However, when a member of the cleaning team was asked about a cleaning schedule they were unable to show us one or describe what cleaning tasks they needed to carry out each day.

Staff had access to personal protective equipment (PPE), such as gloves and aprons. We observed staff regularly using appropriate PPE and advising visitors to use PPE where appropriate. We saw that patients with suspected norovirus were cared for using personal protective equipment and were appropriately isolated to ensure compliance with the trust’s infection prevention and control policy. There were multiple wards with side rooms available for use when patients had a suspected communicable infection. The majority of side rooms had ensuite facilities. We saw that all rooms being used by patients with communicable infections were identified with isolation notices on entry to the side rooms to ensure staff wore appropriate PPE. We also observed staff talking to visitors and advising them of the relevant precautions required to prevent the spread of any infection. During observation of nursing handovers we heard that patients with infectious conditions were highlighted to staff to ensure all necessary precautions were followed by all staff. Staff described the process carried out if there was an outbreak of norovirus, which had occurred during our inspection. We were told that each bay within the ward would be assessed by the infection control team and samples would be sent for analysis as appropriate. The ward was then closed to new admissions and an action plan was put into place with the multidisciplinary team for management of the patients. Information regarding the outbreak
was then cascaded to staff members and a notice was put at the entrance to the ward. We observed this in practice.

Staff used additional control measures to prevent the spread of infection, for example disposable curtains were used around bed spaces which were date labelled to indicate they had been changed in line with trust policy. The trust used ‘I am clean’ stickers which were easily visible and documented the last date and time that equipment had been cleaned. In the dirty utility or sluice area where bed pans and commodes were stored we saw that the majority of these had ‘I am clean’ stickers attached to indicate they had been cleaned after use and were ready for the next patient use.

Clinical waste was not always stored and disposed of appropriately. We found sharps disposal bins located appropriately which ensured the safe disposal of sharps, for example needles. Labels were completed to inform staff when the sharps disposal bins had been opened. However, we saw that in some areas full sharps bins were not always collected regularly and were stored in areas such as the sluice whilst awaiting collection. In the discharge lounge there were two full sharps bins on the corner of the desktop which were not closed and could be easily knocked over. The sharps bins contained used needles which could be hazardous to patients and staff if they fell out.

We saw that staff recorded the insertion of urinary catheters within the patients’ medical notes. The details included the date, responsible clinician and type/ size of catheter used. The records also identified the monitoring and removal of urinary catheters. This was in line with the trust policy for indwelling urethral catheter insertion and management. The trust had a policy for the prevention of intravascular related infections which stated that patients who needed a vascular access device had the risk of infection minimised through safe insertion and maintenance techniques. We saw evidence that patients who had intravenous cannulas in situ, which required a daily review had been documented in the nursing records.

**MRSA, Clostridium Difficile and ECOLI**

We asked the trust to provide data for MRSA bloodstream, clostridium difficile, and escherichia coli infection rates across the medicine division.

They provided the following data:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>Dec 17</th>
<th>Jan 18</th>
<th>Feb 18</th>
<th>Mar 18 (to date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C.difficile</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>E.Coli</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>TBC</td>
</tr>
</tbody>
</table>

Infection rates were on display on entry to each ward which included number of incidences of MRSA bloodstream and *clostridium difficile*.

We saw that there was a trust wide policy for MRSA and that this policy was in date and advocated the screening of all high-risk patients and those patients admitted to high risk units,
such as acute medical wards. The trust aimed for the early identification of patients carrying MRSA to ensure timely isolation of patients and commencement of the appropriate treatment.

Environment and equipment

Although the service generally had suitable premises and equipment, there was a backlog of routine maintenance issues which had not been addressed.

Throughout the inspection we saw that entrance to wards was through swipe card access for staff or call bell access to visitors. In addition, on some wards there was a keypad requiring a code to be entered in order to exit the ward. There were, however, two occasions when we were able to enter wards freely as the doors were left open.

On the main wards each bed space was provided with a bed, armchair, patient locker and an over bed table. We saw that wards were a combination of single rooms and multiple bedded bays, usually four or six beds per bay. Medical services wards varied in number of beds and design, but were appropriate to the delivery of service. For example, the acute cardiology unit had been purpose built and had extra-large bed space areas in order to accommodate monitoring equipment. The acute medical unit had a large number of side rooms, which facilitated the isolation of patients with potentially communicable diseases or those who required additional privacy as they were at the end of their life. All accommodation was single sex with separate male and female bathroom and toilet facilities for each bay area and side room. However, in the discharge lounge there was only one toilet area which was shared. Since this was used as an escalation area this could result in a breach of patients’ privacy and dignity. On ward 9A there was a broken male toilet which had been reported in February 2018 and was still unfixed at the time of inspection. There was another male toilet available for use on the ward but the availability of toilet facilities was reduced.

The AMU assessment ward was an acute medical ward made up of 14 beds, two trolleys and one treatment room. Staff members informed us that the trolleys and the bed in the treatment room where often used as beds for patients. We saw the trolleys in use during our inspection and privacy screens were used to maintain patients’ privacy and dignity. Staff members informed us that on occasions the trolleys were used for overnight stays, which had occurred the night before our arrival. As soon as a bed became available, either on the assessment unit or on an appropriate ward the patient was transferred.

There were some ward areas in the older block of the hospital which looked run down and in need of maintenance, for example we saw areas of peeling paintwork, damaged plaster and bathroom flooring which had become unstuck and was lifting away. The process was for all maintenance issues to be escalated to the estates department by the ward clerk. We noted that maintenance issues were logged accordingly and actions were generally in place. However, staff were unable to explain why the maintenance issues we had found had not been addressed.

On most wards we saw that the clean utility and storage areas were tidy and well organised with cupboards and shelves clearly labelled and appropriately stocked. We noted that each item had a cost per unit label to remind staff to use resources effectively. Most rooms containing clinical equipment items were locked by means of a digital keypad requiring a code to access the room. However, there were some storage rooms containing items such as dressings which we found unlocked; staff told us that these rooms were only locked at night. The locked clinical storage
rooms contained various treatment items such as infusion sets, items for cannulation and venepuncture and food supplements. During the inspection we noted that the clinical items we checked were all within their expiry dates.

Store rooms also contained larger items of equipment such as intravenous infusion stands, and dressing trolleys. A range of electrical items such as infusion pumps, bladder scanners and nebulisers were stored in these rooms. There were systems in place to maintain and service equipment as required. Equipment had electrical testing stickers with appropriate dates. The electrical testing was an inspection of electrical appliances and equipment to ensure they were safe to use. There was also a requirement for medical equipment to be safety checked annually. During our inspection we found that all items we looked at had been safety checked within the last year in accordance with trust policy. After use these items were returned to an equipment library where there was a process for cleaning equipment and ensuring it was in date for testing before it was made available for next use. Larger items of equipment such as hoists had separate annual service contracts to maintain their fitness for purpose. On ACU we saw that one hoist did not have a sticker indicating the last date which it had been serviced. This was raised with the nurse in charge who reported it to the estates department.

On ward AMU Green there was no space to store intravenous (IV) fluids. Staff told us they had to share the IV fluid stock with the neighbouring ward ACU and they were not allowed to order their own supply. This meant staff had to leave the ward to prepare the IV fluids and return which caused a period of time where staffing figures were reduced on a ward which did not always have the planned number of staff for each shift. Staff told us this created additional pressures to the ward. Staff confirmed this had been escalated and were told that an appropriate storage area for the ward was being sought: however, it had still not been addressed.

Resuscitation ‘crash’ trolleys containing medicines and equipment required in an emergency were accessible. Most crash trolleys were safely secured with tamper proof seals, apart from one on ACU where the seal was found to be broken. This was highlighted to the nurse in charge who spoke with the ward staff and told us that the trolley had been checked earlier that day and staff had forgotten to replace the seal tag. The seal was replaced as soon as it was highlighted to the nurse in charge. Regular checks were in place to ensure emergency medicines were available and safe to be used. Daily checks were carried out and recorded to ensure that the trolley was sealed with a numbered tag, the oxygen cylinder was full, and the defibrillator pads were attached. A weekly check was also carried out by two staff members when the tamper proof seal was opened to check all stock within the resuscitation trolley and a new tamper proof seal was added; this was recorded. However, we noted the resuscitation trolley on 11A was not checked for three days in March 2018 and on ACU there were three dates in March 2018 when the checklist was not fully completed or signed. We found that all drugs and equipment on the resuscitation trolleys we checked were in date.

PLACE audit results were requested and the trust provided data from September 2017. The audit considered a variety of assessment domains including cleanliness, privacy, maintenance, dementia and disability. It was carried out across nine wards in the medical division and the results were ‘very confident’ for seven wards and ‘confident’ in the remaining two wards. We saw that there was a PLACE action plan set up to address any areas of concern found during the audit. These action plans were presented at the divisional patient experience group. Each action had a named lead and timescale for achievement and progress against achievement of the actions was monitored.
Assessing and responding to patient risk

Risks to people who use the service were not consistently assessed and hence patient safety was not always monitored and maintained. There were clear and comprehensive risk assessment tools available but they were not always fully completed for all patients. There was little evidence of personalised action plans in response to identified risk. Venous thromboembolism assessments were not consistently completed. However, staff identified and responded appropriately to the changing risks of patients, such as deteriorating health and well-being or medical emergencies.

All patients were assessed on admission using a national risk assessment tool in nutrition, falls risks, manual handling needs and skin integrity. We saw that initial assessments were completed within 24 hours of admission. Each patient had two files which contained information relating to their current admission. One file contained all medical notes and the second was a bedside folder which contained a copy of all nursing risk assessments and care records, such as observation charts, fluid balance charts and food charts and included current medication charts.

We looked at 39 records and found there were omissions of recording of observations and risks in 25 records; the number and type of omissions varied between patients. For example, in 12 of the records there was either no venous thromboembolism (VTE) assessment or no reassessment after 24 hours. VTE assessments assess a patient's risk of developing a blood clot and in line with national guidance all patients should receive a VTE assessment on admission and each patient should be reassessed after 24 hours to confirm whether treatment is appropriate. This meant that some high risk patients could have developed a blood clot which could have gone unnoticed.

We asked the trust for VTE assessment audit results which confirmed that during March 2018 VTE assessments and re-assessments were not completed consistently and the division did not meet the compliance target of 100%. Compliance for completing VTE assessments on admission was between 60% and 100% with an average of 85% compliance. For VTE reassessment after 24 hours compliance was between 0% and 100% with an average of 50.6% compliance.

In 10 sets of records reviewed we found that intentional rounding charts were incomplete, often missing the frequency and times that checks should be performed. Intentional rounding is a structured process whereby nurses in hospitals carry out regular checks with individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of essential items for example drinks and call bells. The aim of intentional rounding is to ensure fundamental aspects of care are delivered reliably and any changing needs are identified and acted upon. Failure to consistently complete intentional rounding means that some patient’s changes in condition may go unnoticed, leaving them at risk of harm or neglect.

In 10 sets of records we saw that although falls risk assessments and pressure risk assessments were completed in line with national guidance, there was no clear action plan documented to address any identified high risk. We found that there were some recommended actions listed when Waterlow scores (a tool for identifying the risk of an individual developing a pressure ulcer) were in the high risk category, but there was no clear documentation of whether these actions had been completed. We saw no evidence that those patients at high risk had their risk reviewed following any actions taken. Similarly, when high falls risks had been identified, there was no
clear individualised action plan documented in the nursing records.

Staff identified and responded appropriately to the changing risks of patients, such as deteriorating health and well-being or medical emergencies. Staff sought support from senior staff as appropriate. Staff told us that an electronic tool had recently been introduced to assist staff in responding quickly to deteriorating patients. Staff recorded clinical observation data such as the pulse, blood pressure and temperature into a handheld electronic device in order to calculate a National Early Warning System (NEWS) score. NEWS is a point system implemented to standardise the approach to detecting deterioration in patients’ clinical conditions. Clinical observations are allocated a number of points depending on whether they are normal readings or not. The total score determined what actions should be taken, for example, how frequently to repeat observations, or whether to refer to a doctor. The system automatically prompted actions when scores reached a trigger threshold. For example, once the NEWS score reached four, doctors were alerted and if the NEWS score reached seven or more, the critical care outreach team were automatically alerted and bleeped through the system. Although the critical care outreach team were available 24 hours a day, seven days a week, staff told us that they could not always respond immediately as their staffing levels could not meet the demand on the service.

In the catheter laboratory staff informed us that on-site medical staff would attend as soon as it was escalated if a patient’s condition, anywhere in the hospital was deteriorating.

On ward 11A staff members told us about a recent incident where staff had failed to escalate a deterioration in a patient in a timely manner. The patient deteriorated suddenly and was later transferred to ITU with acute sepsis. Staff informed us they were awaiting a decision as to whether this would be fully investigated as a serious incident. However, in the meantime, further training had been identified for staff regarding identifying and managing a deteriorating patient as a result of the incident.

There was evidence of a sepsis 6 care bundle being used in the records that we reviewed across the medical wards. Sepsis 6 is a nationally recognised six-step care bundle that should be implemented within one hour if sepsis is suspected. The steps are:

- Administering oxygen
- Taking blood cultures
- Giving IV antibiotics within a defined timescale
- Giving IV fluids
- Taking lactate measurements
- Monitoring urine output

The diabetes service had implemented an outreach team who visited all diabetic patients admitted to the hospital to discuss and agree a specialist care plan. The diabetes outreach team had devised a specialist foot assessment for ward staff to complete. This included a screen to assess skin condition, the presence of broken skin, ulcers or necrosis, and an examination of the sensation and any pain in the foot. If any of these symptoms were present the patient was referred to the diabetes and podiatry teams for specialist management.

The wards had processes and procedures in place to support patients with any mental health needs including referral to specialist mental health services within the trust. Records seen
identified when referrals had been made to mental health services. However, care plans we reviewed were generally not holistic or person centred and did not always consider patients mental health needs alongside their physical needs.

We observed handovers on three wards between night and day shift nursing staff and found that they were structured and methodical. We observed that handovers shared relevant information; staff discussed outstanding tasks, those patients requiring further review and those at risk of deterioration. This included for example information about patients with high fall risks, infection control risks needing to be barrier nursed and those with do not attempt resuscitation (DNACPR) orders in place. We heard staff identify patients with special support needs, for example those with learning disabilities or dementia and staff referred to patients preferred names. On two wards the handover process was completed in two parts where limited information was discussed at the patient’s bedside in order to maintain confidentiality. This was followed by a briefing at the nurse’s handover during which patient information was shared with staff in private. However, on ward 9A, the handover was all completed at patients’ bedsides and we observed a lack of privacy and confidentiality of patient information. The staff spoke about each patient’s full clinical history at the end of the bedside and did not attempt to keep their voices to quiet confidential levels. On this ward, the handover process was not patient centred and staff did not greet or address patients during the process.

Patient moves per admission

The trust was not able to provide any information with regards to patient moves, even those undertaken at night. The trust provided the following statement:

“The information requested is currently not available, partly because of the newly implemented systems. Our electronic system is used to allocate beds and every move, if and when it occurs should be recorded on the system. Patients are moved for several reasons, mainly for clinical reasons, such as appropriateness of ward, needing a speciality bed, infection control. Patients who are also outliers on a ward are moved to the most appropriate ward when that becomes available. We monitor this on a daily basis through Operations Centre. As part of our winter planning we are implementing revised plans for the safe management of medical outliers in the Trust.”

(Source: Trust Routine Provider Information Request (RPIR) P53 - Ward moves)

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Although there were enough medical staff, we found that there were not always enough nursing staff. Fill rates showed that nurse vacancies had been recruited to near full establishment levels, however, on a daily basis, nursing shift actual staffing did not always meet planned staffing levels.
Nurse staffing

The trust had reported their staffing numbers below for year of 2016/17 and year to date which covered April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th></th>
<th>2017/18 YTD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
<td>Fill rate</td>
<td>Actual staff</td>
</tr>
<tr>
<td>Medical care</td>
<td>532</td>
<td>647</td>
<td>82.2%</td>
<td>542</td>
</tr>
</tbody>
</table>

The fill rate for nursing staff in 2017/18 year to date was higher than 2016/17. However, the actual number of staff had remained similar whereas the number of planned staff has decreased.

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

Staffing was raised as a concern by all the nursing staff we spoke with. They told us that staffing issue were due to both vacancies and long-term sickness. We asked staff if they reported staffing concerns and some staff told us that they had completed incident reports to raise their concerns. However, staff members on one ward told us that they had been asked by their ward manager not to complete further incident forms regarding staffing concerns. Staff told us that the winter pressures had provided an increased demand on staffing numbers.

Matrons and ward managers told us one of the biggest risks to their areas was staffing, however they told us the trust had been proactive in recruitment. We were informed that the staffing establishment for each ward area was reviewed every six months, although there was no evidence given to support this.

Wards displayed their planned and actual staffing numbers at the entrance to each ward, which reflected the actual number of staff on duty. We saw that there were regular occasions when actual staffing numbers did not meet planned staffing numbers for both nursing and care support worker (CSW) shifts.

For example, during the inspection we found the following planned and actual staffing levels demonstrating that on nine out of 30 occasions, actual staffing levels did not meet what had been planned:

<table>
<thead>
<tr>
<th>Ward /Date</th>
<th>Planned-Early shift</th>
<th>Actual-Early shift</th>
<th>Planned-Late shift</th>
<th>Actual-Late shift</th>
<th>Planned Night shift</th>
<th>Actual-Night shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>9B 20/03</td>
<td>Qualified 5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>CSW</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>10B 20/03</td>
<td>Qualified 4</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>CSW</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>9AS 21/03</td>
<td>Qualified 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>CSW</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Staffing was reviewed on a daily basis to ensure staffing levels for each shift on each ward met patients’ dependency and acuity. A matron was dedicated each day with responsibility to oversee this. Any staff shortages were highlighted using the safer care staffing tool which was completed by each ward on a daily basis. The tool enabled nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflected patient needs. Ward managers reviewed and reported staffing on a daily basis in line with the trust’s staffing tool which took into account nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas of pressure and allocate staffing across the organisation. However, we were told that when staffing was considered through the daily safe care meetings, the environment was not considered as part of the acuity. This meant that on AMU which was a ward of 16 bedded side rooms, where there may have been a need for additional staffing support to monitor patients in side rooms which was not factored in to the safer care staffing calculations.

Any shortfall in staffing needs was escalated to the heads of nursing who moved staff to ensure safe numbers across all inpatient areas. Staff told us that it was common place for them to be sent to cover other wards. On AMU green one staff member informed us that if the actual staffing levels remained below what was planned, they would look at the experience of the staff to ensure more experienced staff were on the wards with most limited staffing. Staff members told us staffing was escalated to senior managers on a regular basis and sometimes the limited staffing numbers impacted on discharge planning.

If planned CSW staffing did not meet actual staffing, student nurses and overseas pre-registration nurses were used to make up these numbers. When wards were short of qualified nursing staff the band 7 ward managers, who were supernumerary for three shifts a week, often performed clinical duties to maintain safe staffing levels.

We were told that where actual staffing did not meet planned for a shift, managers tried to cover the shifts with existing staff working extra shifts or bank staff. It was also common practise for nursing staff to be moved from their usual ward in order to cover other wards where there were staffing shortages. Nursing staff told us they preferred their own areas because they knew all of the team and knew they had the required skills to safely care for that group of patients. Staff also said different wards had different ways of working, for example, where they write and store patient notes. Matrons were aware some staff did not like to me moved. Staff understood the reasons for moving and the importance of patient safety. The trust were aware staff did not like to be moved and had recently introduced one day a week when staff would only be moved in exceptional circumstances.

Vacancy rates
From December 2016 to October 2017, the trust reported a vacancy rate of 14.9% in medicine. This was above the trust’s target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
The wards did not always have a full establishment of staff, for example on Ashwell ward the overall planned establishment was 17.4 whole time equivalent (WTE) registered nurses and 15.5 WTE unregistered nurses compared to the overall actual establishment of 14.8 WTE registered nurses and 13.2 WTE unregistered nurses. This was further impacted by the fact that the ward usually had 24 beds but at the time of our inspection, had 28 beds open due to escalation planning. On ward 11A there were four WTE registered nurse vacancies and 0.19 WTE unregistered nurse vacancies. We were informed positions had been advertised and recruitment was in process to fill some of these vacancies.

The actual vacancy rates for nursing staff were much higher than the trust target. Managers explained that there was a national issue with nurse recruitment and that they were actively trying to recruit nurses to vacant posts. We were told that open days were regularly held to try and attract new staff and had recently recruited 50 additional nurses. The trust had several overseas nurses in post within medicine who were completing the objective structured clinical examination (OSCE) process and it was planned that this would be completed in the near future. This enabled nurses from overseas to register with the Nursing and Midwifery Council (NMC) and practise as registered nurses within the trust.

**Turnover rates**

From December 2016 to October 2017, the trust reported a turnover rate of 18.6% in medicine. This was higher than the trust’s target of 12.7%.

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

The actual turnover rate for nursing staff was significantly higher than the trust target.

**Sickness rates**

From December 2016 to October 2017, the trust reported a sickness rate for nursing staff in the division of medicine of 4.0%. This is above the trust’s target of 3.3%.

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

**Bank and agency staff usage**

The trust provided nursing quality indicator data which showed that nursing bank and agency use was regularly above the trust target. For February 2018 bank and agency use across the medicine division for the month was red or amber, rated against targets for all wards except two.

The trust target for agency staff use was 2% and usage in February 2018 across the division ranged from 0.1% to 19.4%. The trust target for bank staff use was 4% and usage during February 2018 was between 4.5% and 31.4%. During the month of March 2018 the trust reported using agency nursing staff to fill 669 shifts and bank staff to fill 1754 shifts across the medicine division.

The trust has reported four of the five areas with highest nursing bank and agency staff use to be in medicine. These are acute medicine (AMU Blue & Green), emergency medicine (Ashwell ward), and elderly care (New barley and Ward 9B). It plans to address the issue through international recruitment.
Staff told us that there was regular use of bank and agency staff. Bank staff were generally the trusts’ substantive staff members, therefore using bank staff meant consistent care to patients and staff were already familiar with the environment and policies and protocols that needed to be adhered to. There was less frequent use of agency staff due to financial constraints as part of the trust cost improvement plan and we were told that there was a cap on a maximum of one agency staff per ward per shift.

The requirement to fill shifts with bank and agency staff was due to vacancies and also some long-term sickness leave which created additional rota gaps.

**Medical staffing**

The trust has reported their staffing numbers below for year of 2016/17 and year to date which covered April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Medical care</td>
<td>232</td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>247</td>
<td>240</td>
</tr>
</tbody>
</table>

Medical staffing fill rates for the current year were higher than the previous year, despite planned medical staffing levels increasing.

During inspection we spoke to junior doctors, registrars and consultants who did not express concerns about medical staffing levels. They reported that rota gaps were rare and were usually filled by locum staff resulting in safe medical staffing levels. Junior doctors informed us that they felt well supported by consultants.

**Vacancy rates**

From December 2016 to October 2017, the trust reported a vacancy rate of 0.5% in medicine. This was below the trust’s target of 6%.

**Turnover rates**

From December 2016 to October 2017, the trust reported a vacancy rate of 12.7% in medicine which is the same as the trust target.
Sickness rates
From December 2016 to October 2017, the trust reported a sickness rate of 0.8% in medicine. This is lower than the trust’s target of 3.3%.

Bank and locum staff usage
Trust data showed that in March 2018 there were 392 shifts filled by medical agency staff and 570 shifts filled by medical bank staff across the medicine division.

The trust has reported one of the five areas with highest medical bank and locum staff use to be in medicine. This is acute medicine and elderly care and the trust planned to address this through recruitment drives.

Staffing skill mix
In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the national average.

Staffing skill mix for the 225 whole time equivalent staff working in medicine at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</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
Records

Staff did not always keep appropriate records of patients’ care and treatment. Records were clear, but not always comprehensively completed or up-to-date. Records were available to all staff providing care, however, this meant that were not always stored securely.

We saw that relevant records were kept for patients and that there were separate sets of records for medical and nursing care. Entries were clear and legible and most entries were dated and signed, although staff did not always document their name and role within the trust. This meant it was sometimes difficult to identify individual practitioners who had made the entries. Stamps containing details of the practitioner’s name and nursing personal identification number (PIN) or general medical council (GMC) numbers, were not used. The use of stamps is recognised as good practise by the general medical council, although it is not currently a recommendation by the professional bodies for nurses or allied health professionals.

We found that occasionally there was a failure to add the patient’s name and identification details on every page within the medical notes. This meant that there was a risk that if notes sheets became loose from the medical folder, some patient records may not be identifiable and could be filed in the wrong patient's record.

We saw that medical notes contained appropriate clinical details and that entries were made by the medical team daily. There was evidence of referrals to other members of the multidisciplinary team (MDT), for example speech therapists and dieticians. Members of the MDT wrote any relevant information in the medical notes to ensure that information was shared appropriately. In the medical records we saw it was documented that all patients had been seen within 12 hours of admission onto the ward and a diagnosis and management plan was in place. During inspection we were told that locks had recently been added to the medical records trolleys to ensure secure storage. Keys were held by the doctors, nurse in charge and ward clerk. However, on wards 9A, SSU and ACU we found that the notes trolleys were unlocked. We were told by staff on SSU that the notes trolleys were only locked in the evenings as staff needed to access the trolley regularly throughout the day. However, this meant that we could not be assured that medical records were being stored securely at all times. When patients were discharged from the ward the medical notes were kept in a filing cabinet until they were coded. Clinical coding is used to classify the diagnosis and treatment of every inpatient for entry into a national database. The filing cabinet which stored medical records awaiting coding was kept in a locked office and the notes were collected on a daily basis to be sent to the trusts main record storage area.

On all wards we saw that the nursing folders were left on desks or tables within bays and were not locked away or kept in a confidential area. The nursing records were not kept at the end of patient’s beds, as is common practise. The folders were left unattended on tables in each bay which were accessible to all ward visitors. There was a risk that this confidential patient information could be accessed by unauthorised people as they were not being kept securely. Nursing record folders included nursing assessment paperwork, care plans and daily running records, along with medicine prescription charts. The nursing assessment documentation, which was completed on admission was not always fully completed or signed. For example, in 15 of the 39 sets of records we reviewed during inspection there were incomplete fluid balance charts where staff had omitted fluid balance totals and / or signatures. Fluid balance charts are routinely
used to assess patient’s hydration levels. Fluid balance charts are only useful in providing appropriate nursing care if they are fully completed. In order to improve care plan completion on Ashwell ward the ward manager had identified team leaders who had responsibility for monitoring care plans on a daily basis to ensure they were completed accurately and subsequent actions were taken as appropriate. This included nutritional care plans and referrals to the dietician, medication, falls care plans and risk assessment and pressure ulcer management and referrals to the tissue viability nurse.

We saw that regular routine patient observations were recorded electronically on a hand held device. The device alerted staff members when observations were due to be taken, and when they were recorded the observations would go from red to green to show they had been completed and recorded.

Ward managers told us that nursing records were subjected to regular record keeping audits. We saw that there was an appropriate tool for completing these audits and that they were carried out monthly on all wards across the medicine division. We were told that 20 nursing records from each ward were audited each month. Audit results for the period January to March 2018 showed that 866 records had been audited across the division and there was the following overall compliance:

<table>
<thead>
<tr>
<th>Category</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient identification</td>
<td>92%</td>
</tr>
<tr>
<td>Medications administration</td>
<td>96%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>93%</td>
</tr>
<tr>
<td>Fluid balance chart completion</td>
<td>97%</td>
</tr>
<tr>
<td>Falls documentation</td>
<td>98%</td>
</tr>
<tr>
<td>Pressure care documentation</td>
<td>98%</td>
</tr>
</tbody>
</table>

The trust did not state what their target compliance for the documentation audit was.

We saw that staff considered patient confidentiality by writing minimal patient identifiable information on the ward patient white boards. On some wards we saw that privacy covers were placed across patient names and details on boards in order to maintain confidentiality.

Staff had access to a health liaison nurse who provided advice about caring for patients with a learning disability. We saw that there was a pilot of a purple star booklet which was designed to be completed by the health liaison nurse and kept within the nursing records in order to share information with ward staff about recommended patient care for patients with a learning disability. We saw that these were comprehensive and well completed for appropriate patients.

The wards had processes and procedures in place to support patients with any mental health needs including referral to specialist mental health services within the trust. Records that we saw identified where referrals had been made to mental health services. However, care plans that we reviewed were general, not holistic or person centred and did not always consider patients’ mental health needs alongside their physical needs.
Medicines

The service usually prescribed, gave, and recorded medicines in line with best practice. Patients received the right medication at the right dose at the right time. However, medicines were not always stored appropriately.

We found all treatment rooms were secure requiring a key code to enter and all cupboards and fridges containing medicines were locked within treatment rooms. We saw that controlled drugs were stored in separate locked cupboards with restricted access to the keys.

We saw that controlled drugs were stored correctly according to the Misuse of Drugs (Safe Custody) Regulations 1973 as amended. Controlled drugs are those at risk of misuse and therefore require additional safety measures. We saw that controlled drug usage was recorded in appropriately secure records, checked and administered by two nurses and audited regularly by the pharmacy team. We saw that the nurse in charge in each clinical area held the controlled drug keys and handed these over to authorised persons only. Stock levels of controlled drugs (CDs) were checked daily across the service. We saw that most records relating to this were completed in specific controlled drug books and that these books were well completed and up to date. However, when we inspected 7A North on 21 March 2018 we found that the register of controlled drugs had not been completed since 17 March 2018. This was raised immediately to the ward manager who said they would talk to all staff members about the importance of the daily checks.

We also noted on AMU Assessment and AMU Green, that when a patient was admitted to hospital with controlled drugs this was recorded appropriately; however, when they were discharged from hospital or transferred to another ward, AMU Assessment did not document the amount returned to the patient and recorded in the register the amount was zero. Therefore, we could not be assured the appropriate amount was returned to the patient.

We did random sample checks of the CD stock within the cupboards and found that all drugs we checked were in date and the stock level correlated accurately with the CD record book.

We saw the results of the quarterly controlled drugs (CD) audit for the medicine division from October to December 2017 which showed compliance of between 43% and 93% for each ward. Common compliance issues included out of date CDs not being removed from stock, failure to complete daily stock checks, and CD cupboard keys not being kept separate from the other keys. However, we noted that the audit reports were escalated and discussed with ward managers, matrons and pharmacists and that any areas of concern were reviewed at a multidisciplinary CD review group in order to develop an appropriate action plan to mitigate risks.

We noted that fridges which stored medication that required to be refrigerated were locked and visibly clean. We saw that continuous temperature monitoring data logger systems were used to facilitate monitoring of medicine room and refrigerator temperatures. The system still required staff to check the data logger and record readings daily, however there were still areas where this was not always regularly undertaken. We could not therefore always be assured that medicines were stored safely or that staff understood what action to take if the temperatures were not safe for medicine storage. For example, on SSU we saw that there were two days in February 2018 when the fridge temperature was not recorded and a further seven days when the temperature was unreadable due to an error with the data logger. The error was reported to pharmacy who
replaced the faulty equipment. There were two dates in both February and March 2018 on SSU when the fridge temperature exceeded the maximum recommended temperature range; there was no evidence that this was escalated or actioned. This meant that temperature sensitive medicines may not have been stored correctly and may have been administered to patients. On ACU there were 18 dates in December 2017, four dates in January 2018 and seven dates in February 2018 when the fridge temperature was not recorded. There was only one date, in December 2017, on ACU where the fridge temperature was recorded as out of range and it was documented that this had been reported to pharmacy in accordance with the trusts policy.

We were told that ambient room temperature was not routinely recorded and staff were unable to tell us if the policy required monitoring of room temperature as well as fridge temperatures. We requested the pharmacy policy for medicinal products which had been produced by the chief pharmacist and was a trust wide policy dated October 2017. The policy included a SOP for monitoring of fridge temperatures but did not include any guidance on monitoring ambient room temperatures. The policy, did, however, include a risk assessment and action plan for when room temperatures regularly exceeded 25 degrees centigrade. Since there was no guidance to prompt staff to monitor and record ambient room temperatures we were not assured that staff could be sure that medicines were always stored safely.

Some wards had a hypoglycaemia (low sugar levels) box which they could use in an emergency which included; a flow chart, glucose sweets, a nutritional drink high in calories and a checklist. We saw the checklist had been completed daily and items were within date

We saw that on most wards, nursing staff completing the medicine round wore ‘do not disturb’ red tabards to ensure they could focus on accurately dispensing medications to patients. Medicines trolleys used for medication rounds were locked and also chained to a wall fixing with a padlock; this ensured that the working stock of medicines was stored securely.

Each ward had a designated pharmacist who would attend the ward every weekday and offer support and advice. This pharmacist was also responsible for checking all medication lists for patients being discharged. A pharmacist we spoke to reported that medication charts were generally completed to a good standard. We were told that doctors were prescribing appropriate medication and doses in line with British National Formulary recommendations and that they were open to challenge by pharmacists.

A ward manager told us that there was a weekly audit of any medication errors and the main error was missing signatures, although this had improved following sharing of audit results. Information from medication errors audits was shared at multidisciplinary medication forum which included representatives from pharmacy, quality and safety, consultants, nurses and specialist nurses and was led by the medicine divisional chair. Actions from this forum were communicated through the clinical governance rolling half days and through medication safety bulletins and the patient safety matters newsletter.

Patient weights were routinely documented on prescription charts and any known allergies or sensitivities to medicines were recorded on most medicine charts. This information is important to prevent the potential of a medicine being given in the wrong dose or in error and hence causing harm. During inspection we reviewed six prescription charts and noted all entries were signed with the dose and route given, allergies were documented as well as the patient weight.
Self-administration of medicines was available following an agreed trust policy to allow patients control and independence with their medicines, for example patients deemed and assessed as competent with their insulin administration. We found there to be a trust wide, in date policy for self-administration of medications for adults (16 +). We saw that each bedside had a medication locker in addition to a personal belongings locker; nursing staff held the keys for these lockers.

We reviewed four patient records on AMU Assessment and three on AMU Green specifically around medicine reconciliation and noted that out of the four records on AMU Assessment, none had undergone a medicine reconciliation. Medicine reconciliation is the process whereby the patient’s current medications are reviewed to ensure the most up to date prescriptions are used. This includes reviewing any GP records and discharge or transfer letters. We raised this with a member of the nursing team who told us the pharmacist visited the ward on a daily basis but was unsure if they carried out any medicine reconciliation. We requested a copy of the medicines reconciliation policy and any medicines reconciliation audits. Audit results from March 2018 showed that most patients on the medical wards had a medicine reconciliation within 24 to 48 hours but all patients had received one within 72 hours.

The diabetes outreach team consisted of nurse prescribers who could provide an insulin initiation service. The lead nurse for diabetes also told us the trust had a self-administering policy which was encouraged so patients continued to self-manage their diabetes.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The trust had a specific policy in relation to “Being Open and the Duty of Candour”. This policy was also signposted in other policies, including the incident reporting policy. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw leaflets available on most wards which informed patients and relatives of the trust’s duty of candour process. Staff were able to describe their responsibilities and explain how they would apply the duty of candour requirements relating to any completed incident.

Duty of candour was contained within the corporate induction for all new staff as well as the annual mandatory health and safety training delivered either face to face or through e-learning to all staff. The training ensured staff felt confident and empowered to hold difficult conversations and to break bad news. We saw that conversations with patients and their relatives were recorded on the incidents that we reviewed. The medicine division reported having applied the duty of candour in 91 cases between December 2016 and November 2017. *(Source RPIR)*

All staff we spoke with told us they were able to report incidents and explained the process for
reporting an incident through the trust intranet system. Staff were able to provide examples of incidents they would report, which included discharge letters not sent at the time of discharge, medication errors, short staffing, falls and pressure ulcers. However, staff on one ward told us that they had been discouraged by the ward manager from completing regular incident forms about short staffing.

Most staff reported that there was active encouragement to report incidents within the trust. Incident reports submitted were reviewed by ward managers who carried out an initial investigation and completed a root cause analysis, if required. It was expected that all incidents submitted through the reporting system were reviewed by the ward manager within 24 hours. Managers told us that they provided one to one feedback about incidents and identified any learning or training needs as a result of the investigation. They told us that the daily safety huddle, ward meetings and email were used as methods to share learning. One nurse described that following reporting of several insulin errors by agency staff an enhanced induction for agency staff was devised. This included additional training on administration of insulin by specialist nurses.

Staff we spoke with said they did not always receive individual feedback when they submitted incident reports.

Trust data showed that there were 2317 reported incidents within the medicine division from 1 October 2017 to 27 March 2018. The highest reporting ward was Ashwell ward with 120 incidents. The commonest themes were falls, medication issues and discharge concerns. National Reporting and Learning System (NRLS) data showed that the medicine division reported 2796 serious patient safety incidents between November 2016 and October 2017. Medicine was the highest reporting division to NRLS within the trust. The commonest reported incidents were patient accidents (635), concerns around access to services, admission or discharge issues (507) and medication (423).

When we spoke with staff members they were knowledgeable about recent incidents, including actions taken as a result of any incidents. They gave us an example of when staff failed to escalate a deteriorating patient in a timely manner. The patient deteriorated suddenly and was later transferred to ITU with acute sepsis. Staff informed us they were waiting for a decision whether this would be fully investigated as a serious incident (SI), however, in the meantime, further training had been identified as a need for staff regarding recognising and managing a deteriorating patient as a result of the incident. Another incident described, was a medication error, where a doctor prescribed the incorrect dose of insulin which was administered by the nurse. This led to the patient becoming hypoglycaemic (low blood sugar). Staff involved in the incident attended refresher training.

All serious incidents were initially investigated and a report was required to be produced within 72 hours. We were told that the 72 hour reports were monitored internally but there was no audit process to formally monitor the compliance with the 72 hour requirement for reports. The heads of nursing told us that there was no report process in place which gave oversight on the status of incident investigations. There was, however, a panel in place to decide if incidents were SIs or for internal review only. This was attended by a panel led by the director of nursing. The need for application of duty of candour was also considered at this panel.
We saw that learning from serious incidents and investigations were displayed on information boards. Learning from serious incidents included ensuring patients were escalated to the matron if there had been a 48 hour wait or more regarding specific care of patients with feeding tubes directly into the stomach (PEG), ensuring patients with learning disabilities were referred to the learning disability team to ensure appropriate support was in place and making sure that the call bell was in easy reach of patients.

**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 January to December 2017, the trust reported one incident classified as a never event for medicine which involved a patient jumping from a window. This occurred in December 2016 but was reported by the trust in the period stated above and was classified as apparent, actual or suspected self-inflicted harm.

*Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)*

We reviewed the investigation and action plan for the never event that happened in December 2016. We saw that it had been fully investigated by a group of senior staff including the lead consultant, director of nursing and the safeguarding lead. A timeline and root cause analysis were completed in order for the trust to understand the circumstances of the never event and learn from the findings. We saw that a seven point action plan document had been put in place to ensure learning was cascaded. Each action had a named lead for each action with target completion dates. One of the actions was reported to be a review of window opening restrictors as the use of an inadequate restrictor had been a contributory factor to the cause of the incident. We checked several windows and observed that window restrictors were in place and functioned effectively. We were assured that the trust had taken all appropriate actions to investigate and learn from the never event.

**Breakdown of serious incidents reported to STEIS**

We were told that a risk and review team made the decision on whether incidents were serious incidents (SI’s) and needing reporting to Strategic Executive Information System (STEIS) or managing internally. This process happened as part of the divisions governance meetings.

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England, from January 2017 to December 2017. All of these incidents occurred at Lister Hospital.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria - four (45.5% of total serious incidents).
- HCAI/Infection control incident meeting SI criteria - two (18.2% of total serious incidents).

*Source: Strategic Executive Information System (STEIS)*
We reviewed the information on STEIS relating to the commonest type of incident; slips, trips and falls. We found that two related to delayed diagnosis of fractures following falls in hospital, one related to a fall sustained when a patient got out of bed/chair without supervision and one fall was when a patient at high risk of falls fell out of bed in a side room. We saw that appropriate investigations had been completed and action plans had been put in place, including staff education, development of a standard operating procedure and improved communication processes between departments. We were assured that the trust dealt with serious incidents comprehensively.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

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 three new pressure ulcers, three falls with harm and seven new catheter urinary tract infections from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Falls</td>
<td>(3)</td>
</tr>
</tbody>
</table>
Total CUTIs

(7)

(Source: Safety thermometer - Safety Thermometer)

We were told that the matron reviewed any themes in reported data, such as high numbers of falls, and investigated any underlying causes. For example, the number of falls in patients who did not wear slippers was highlighted and as a result, all patients are prompted to wear slippers for safety. On ACU it was found that lying and standing blood pressures weren't being consistently recorded with all patients and once this had been addressed the incidence of falls on the unit decreased.

Major incident awareness

The service planned for emergencies and staff understood their roles if one should happen.

The divisional leads explained that there was a major incident plan in place which was a trust wide policy and there were business continuity plans for each clinical area. The plans were available on the staff intranet ‘knowledge centre’. We were told that the plans had been tested through desktop exercises but that had been put into place twice recently; once when there was a nursing home fire locally and once during a national cyberattack on NHS IT systems. The heads of nursing reported that the plans had worked well.

We were told that in addition there were fire evacuation plans in place which were discussed at annual training events. All new staff members to the ward areas were walked through the fire evacuation plan specific to the ward area. There was also a specific renal disaster plan in place for use in the event of disruption to the dialysis service through natural disasters or by other types of emergency situations, such as electrical power blackouts.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Nursing staff informed us they were able to access policies and standard operating procedures (SOPs) relevant to their role on the local knowledge centre and hard copies were also available in the ward manager’s office.

The trust had policies in place for the management of, for example, sepsis and acute kidney injury, which were in line with the National Institute for Health and Care Excellence (NICE) guidance. The
endoscopy department completed the national inflammatory bowel disease audit, alongside local audits of gastro intestinal bleeds. Staff showed us standard operating procedures (SOPs) and local guidelines for diabetic ketoacidosis (DKA) and chronic kidney disease (CKD) which were readily available to staff on the trust intranet (knowledge centre). We were told that protocols for diabetic care such as diabetes in pregnancy and diabetic foot care protocols based on NICE (QS6) Diabetes in adults had been co-written by consultants and diabetes specialist nurses. Staff told us that there were regular local audits of compliance with these protocols. We saw evidence of audit against diabetic protocols and presentation of the findings. There were trust wide guidelines for hyperkalaemia (high sodium levels in the blood) based on NICE guidance which had been written by the renal consultants and were regularly referred to by staff. Within stroke care there was clear pathway for care developed in line with national clinical guidelines for stroke in adults.

The medical service worked in conjunction with NICE (QS3) Venous thromboembolism (VTE) in adults: reducing the risk in hospital for patients’ initial assessment. However, we found no evidence that the trust complied with NICE guidance regarding the re-assessment of patients within 24 hours of admission for risk of VTE and bleeding.

The trust had a policy for management of sepsis (blood infection) and a sepsis bundle care pathway which could be implemented if sepsis was suspected. “Sepsis boxes” were available on the wards. Sepsis boxes were bright yellow box folders which contained a sepsis proforma, antimicrobial guidelines, neutropenic guidelines, the sepsis trust policy and information on how to access sepsis e-learning. When we checked the sepsis box on AMU we found that there was no information on e-learning and that the neutropenic guidelines were out of date since March 2017. The boxes were designed to be easily accessible to nursing and medical staff which helped to reduce the time between a suspicion that the patient had sepsis, and commencement of treatment. Staff told us they were aware of the sepsis box.

The cardiac catheter laboratory used an Integrated Care Pathway (ICP) which had been adapted from the World Health Organisation (WHO) guidelines for safer surgery checklist. This ensured that the procedure was explained to and discussed with the patient pre-procedure. Post-procedure information was documented within the ICP and a full handover was provided to the recovery nurse.

Patients on the medical wards were generally reviewed by a consultant led ward round every day, seven days a week.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

We saw that wards had protected meal times and patients had a choice of food. On ward 9A a menu choice was offered a day in advance from which patients could choose their preferred meal option. A menu choice was also offered for patients requiring a special diet, such as soft or puree. We observed that the ward sister supervised the meal service in order to ensure that special dietary needs were met. We saw caterers serve meals and noted that food looked
appetising. We observed that the food was served hot from the trolley and that meals were left within reach of patients. However, several of the patients we spoke to reported that the food was not appetising and that they did not enjoy it.

On SSU we saw a nurse encouraging a patient to eat snacks and fetching them a fresh drink to replace a cold cup of tea. The nurse spent time trying to encourage the patient to eat and drink when they had a poor appetite in order to promote their health and wellbeing.

The Malnutrition Universal Screening Tool (MUST) was used in the wards and medical units. The MUST tool is a five-step screening tool to identify patients who are malnourished, at risk of malnutrition (undernutrition), or obese. The tool also includes management guidelines which can be used to develop a care plan. Patients who were nutritionally at risk were referred to a dietician.

Patients’ nutrition and hydration status were assessed and recorded on all the medical wards. We observed that the fluid balance charts used to monitor patients’ hydration were not always completed fully. During inspection we found that 15 out of 39 records that we checked had incomplete fluid balance charts where cumulative totals were not completed. This meant that staff could not be reassured that patients were drinking enough fluids to help their recovery and prevent dehydration.

Referrals to dieticians or Speech and Language Therapists (SALT) were made, but the records we read did not reflect these referrals had been followed up or that patients had an action plan in place. This meant there was a risk of patients’ specialist nutritional needs being overlooked.

However, on the stroke wards there was evidence that stroke patients’ swallowing ability was assessed to ensure that nutrition and hydration was provided through an appropriate route. This was in line with the Sentinel Stroke National Audit Programme (SSNAP) recommendations. We saw documentation that patients were given a swallow screening with four hours of presentation at the hospital with a suspected stroke and a formal swallowing assessment within 72 hours.

**Pain relief**

Patients we spoke with confirmed that they had received pain relief medication when they required it.

We saw in the records that staff used the Abbey Pain Scale assessment tool for people with dementia or delirium type illnesses. For patients with a learning disability the disability distress assessment tool for pain was used. However, we did not see any evidence of audits of the effectiveness of pain management in patients.

**Patient outcomes**

The effectiveness of care and treatment was measured and findings were used to improve them. They compared local results with those of other services to learn from them. There was variable performance in a number of national audits relating to patient safety and treatment, however action plans were in place, where required, to improve the quality of care.
Information about the outcomes of patient’s care and treatment, for both physical and mental health (where appropriate), were routinely collected and monitored. This was done through local audits and national audits. Examples included national lung cancer audit, the stroke audit and national diabetes inpatient audit. There was variable performance in a number of national audits relating to patient safety and treatment. We saw that specialities discussed audit results as part of their local governance and where necessary had action plans to address any developments. The trust had a process for clinical audit project registration. We saw completed outcome forms for audit projects and documents evidencing that the audit results had been presented to staff.

Summary hospital mortality indicator (SHMI) and hospital standardised mortality ratio (HMSR) data from NHS England is shown below:

**Summary Hospital-level Mortality indicator (SHMI)**

For the 12-month period from Jul 16 - Jun 17, SHMI was as expected with a value of 1.02 (compared to 1.0 for England) and 2,395 deaths compared to an expected 2,345 deaths.

**Hospital Standardised Mortality Ratio (HSMR)**

For the 12-month period from Jul 16 - Jun 17, HSMR was as expected with a value of 96.51 (compared to 100 for England) and 1,444 deaths compared to an expected 1,496 deaths. Weekend HSMR is within expected range for this time period.

There was active participation in research within medicine; for example, there were research nurses within the diabetes, stroke and cardiology specialities. The research nurses had a daily presence on the wards and worked to recruit appropriate patients to several national research trials including an antiplatelet trial and a triple therapy trial within cardiology. A research strategy was introduced into the trust in 2016/17 and there had been a significant increase in the number of patients participating in research studies since the introduction of the strategy. Trust data showed that 2772 patients were recruited to research studies in 2017/18 compared to 1634 patients in 2013/14. The trust reported currently being involved in active recruitment to 17 cardiology, 6 diabetes and 20 renal research studies. Participation in research trials meant that the trust was ensuring patients had access to current and developing treatment therapies.

**Relative risk of readmission Trust level**

From September 2016 to August 2017, patients at the trust had a similar to expected risk of readmission for elective admissions and non-elective admissions when compared to the England averages.
Elective Admissions – Trust Level

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.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical oncology (previously radiotherapy) and medical oncology had a higher than expected risk of readmission for elective admissions

Non-Elective Admissions – Trust Level

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.

- Patients in general medicine and cardiology had a similar to expected risk of readmission for non-elective admissions
- Patients in nephrology had a lower than expected risk of readmission for non-elective admissions

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Lister Hospital

From September 2016 to August 2017, patients at Lister Hospital had a lower than expected risk of readmission for elective admissions and a similar to expected risk of readmission for non-elective admissions when compared to the England averages.
Elective Admissions - *Lister Hospital*

![Graph showing elective admissions](image)

*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.*

- Patients in gastroenterology, nephrology and cardiology had a lower than expected risk of readmission for elective admissions

Non-Elective Admissions - *Lister Hospital*

![Graph showing non-elective admissions](image)

*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.*

- Patients in general medicine and cardiology had similar to expected risk of readmission for non-elective admissions
- Patients in nephrology had a lower than expected risk of readmission for non-elective admissions

**Sentinel Stroke National Audit Programme (SSNAP)**

Lister Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, April to June 2017 and grade A in the audit for January to March 2017
### Team-centred KI levels

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>B A</td>
<td></td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>C C</td>
<td></td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>C C</td>
<td></td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>B B</td>
<td></td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A A</td>
<td></td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>A A</td>
<td></td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>B A</td>
<td></td>
</tr>
<tr>
<td>8) MDT working</td>
<td>B B</td>
<td></td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>B B</td>
<td></td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>A A</td>
<td></td>
</tr>
</tbody>
</table>

**Team-centred SSNAP level**

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A A</td>
<td></td>
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</tbody>
</table>

**Team-centred Total KI level**

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A A</td>
<td></td>
</tr>
</tbody>
</table>

**Overall scores**

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A A</td>
<td></td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A A</td>
<td></td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A A</td>
<td></td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>A A</td>
<td></td>
</tr>
</tbody>
</table>

1 Included in IM reporting, indicator SSNAPD02

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**Heart Failure Audit**

**In-hospital Care Scores**

Results for East and North Hertfordshire NHS Trust in the 2015 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care.
Discharge Scores

Results for East and North Hertfordshire NHS Trust results were better than the England and Wales average for seven of the nine standards relating to discharge.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

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 103 inpatients with diabetes at Lister Hospital. This was equal to 19.3% of the beds audited which places Lister Hospital in quartile 3 for numbers of diabetes patients occupying hospital beds. Of those 103 inpatients 76.4% 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 1. There was a decline in the satisfaction of diabetic inpatients as in 2015 this rate was 84.9%. (Source: NHS Digital)

This was discussed with a consultant in diabetes who explained they had looked at the reasons for decreased patient satisfaction and identified three areas of dissatisfaction:

- Meals were not perceived as diabetic specialist nutrition by patients
- Patients did not feel they had sufficient control in managing their own diabetes
- Patients felt staff should have more specialist diabetic knowledge

In response to these areas, the following actions were taken:

- Patients were educated about diabetic diets as there was a misunderstanding that diabetic food needed to be a special diet but really it should simply follow healthy eating principles.
- There had been a focus on increased self-management strategies for diabetic patients so that they felt more empowered to be in control of their condition
- A targeted staff education programme to increase diabetes knowledge in staff working on general medical wards had been put in place.

Myocardial Ischaemia National Audit Project (MINAP)

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

From April 2015 to March 2016, 51.0% of none S-T Elevation Myocardial Infarct (nSTEMI) patients were admitted to a cardiac unit or ward at Lister Hospital and 98.4% were seen by a cardiologist or member of the team compared to England averages of 55.8% and 96.2% respectively.

The proportion of nSTEMI patients who were referred for or had angiography at Lister Hospital was 63.7% compared to an England average of 83.6%.

(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 54.0%, which was worse than the audit minimum standard of 90%. The 2015 figure was 92%.
The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 8.3%, this is significantly worse than the national level (24.0%). The 2015 figure was 26.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 63.6%, this is not significantly different to the national level (64.0%). The 2015 figure was 64.0%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.7%, this is not significantly different to the national level (69.0%). The 2015 figure was 68.0%.

The one year relative survival rate for the trust in 2016 is 35.8% which is not significantly different to the national level (38.0%).

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 77%. This was below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 41%. This was below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 100%. This met the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

(Source: Royal College of Physicians)

We saw that performance in national audits was monitored by senior managers in the division and that a gap analysis and an action plan was completed where performance did not compare favourably with the England average. These tools considered performance levels against national outcomes and graded the risk of any underperformance. Recommendations were made in the form of action plans in order to improve performance. We saw minutes of a departmental stroke meeting which showed that these action logs were shared and discussed in an attempt to drive improved performance.

Competent staff

The service did not make sure that all staff were competent for their roles. Managers did not consistently appraise all staff’s work performance through means of an annual
appraisal or regular supervision processes. No appraisal information was provided about medical staff.

Appraisal rates
All staff we spoke to, except one, reported having had an appraisal within the last 12 months, during which they were able to set learning objectives for the coming year. The one staff member who hadn’t had a recent appraisal told us this was due to having several changes of manager resulting in her not having had an appraisal for over two years. However, trust data for appraisal rates across the medicine division did not support what staff told us. From April 2017 to October 2017, 82.9% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%. There was no appraisal information provided about medical staff. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>18</td>
<td>18</td>
<td>100.0</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>74</td>
<td>78</td>
<td>94.9</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>15</td>
<td>16</td>
<td>93.8</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>53</td>
<td>62</td>
<td>85.5</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>116</td>
<td>137</td>
<td>84.7</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>378</td>
<td>463</td>
<td>81.6</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>192</td>
<td>247</td>
<td>77.7</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
In four out of seven staff groups within medicine the trust target rate for receiving an appraisal was not met.

Some wards were however able to produce locally held data which showed good compliance with appraisal targets of up to 100% in some areas. The division’s nursing quality indicators showed appraisal compliance of between 64.5% and 100% across the medical wards in February 2018. Out of 13 wards, four had achieved target compliance (90%) but nine had not.

We asked nursing staff if they had received clinical supervision; they did not report having regular supervision meetings with managers in order to provide support and monitor the individual’s performance.

Not all staff had received sepsis training. The trust reported that 341 out of 580 (59%) registered nurses in the medical division had undergone sepsis training. The type of training offered varied between formal training days, update sessions or e-learning. Staff told us that the sepsis nurse in the trust visited wards on a six monthly basis to provide teaching sessions. There was no target for training compliance and sepsis training was not mandatory. There was a sepsis policy available on the staff intranet, known as the knowledge centre.

In addition to mandatory training, staff had access to additional training on subjects that supplemented the care they provided. For example, staff completed training in dementia care to assist with the management of patients admitted with the condition.

Overseas nurses had been recruited to work at the trust. They commenced their role on a lower grade initially which gave the new staff members time to complete their competencies. They were also required to complete written tests before they were included within the trained nurse numbers for staffing.

We saw that there was an agency staff induction checklist used to orientate any agency staff to the wards which covered health and safety, expectations, and a ward orientation. We were told that agency staff initially worked with substantive staff until competency had been established.

Volunteers worked in some areas of the medicine division and received an induction prior to working within clinical areas. We saw that there was a SOP for volunteers that explained the process for recruiting volunteers and identified that they needed to complete identity and disclosure and barring checks prior to appointment. There was a training programme in place for all new volunteers that included topics such as health and safety, manual handling, safeguarding and infection prevention and control.

On Ashwell ward we were told that all band six nurses were trained mentors and the ward manager had allocated them a team of trained and untrained staff to manage. This included ensuring all training was up-to-date and appraisals were carried out.

New staff members had a three day induction at the start of their role within the trust and worked on a supernumerary basis for two weeks. This allowed staff to become familiar with trust policies and protocols.

There was a varied culture of encouraging ongoing staff development within the trust; most of this training was facilitated by the specialist nurses. Senior and junior staff told us there was very little resource available to fund external training. There were dedicated link nurses for specific conditions on the wards, who had undergone specific training to carry out this role. This included topics such as infection prevention and control, diabetes, tissue viability, Parkinson’s disease,
palliative care and dementia. We were told that link nurse’s study days occurred every three months.

There were specialist nurse posts in some specialities such as diabetes and stroke which provided regular training to staff as part of their core role.

There were nurse prescribers in the diabetes outreach team who were able to provide an insulin initiation service. All nurse prescribers had undertaken additional training relevant to their role. The division supported those who wished to progress and funding was sought to support staff members in additional training.

Staff told us that a training pathway was set up for nurses that had completed their 18 months rotational program to enable them to progress into further roles which the trust believed would help with staff retention.

One ward manager we spoke with was completing a level five management training programme. CSW staff reported they were supported to attend study days offered in house. Nursing students told us that they were supported by two mentors who provided effective teaching and completed sign off of their basic nursing skills achievements.

Junior doctors told us that they felt well supported by consultants. We saw that there was a comprehensive junior doctor induction programme. Doctors told us that there were several in-house development opportunities within the trust. We were told about a foundation programme for junior doctors which covered seven academic rotations. In addition, there was a senior clinical fellow in post whose role was to offer regular formal teaching and clinical supervision in endocrinology and diabetes to registrars. However, a junior doctor told us while they were rotating on the gastroenterology ward, they also had to cover acute medical patients on other wards and that this meant they missed out on essential training in the gastroenterology department. This group of junior doctors were also only allowed to take annual holiday during their gastroenterology rotations, which meant they missed further learning opportunities.

Ward 11A was a respiratory ward which provided non-invasive ventilation (NIV) for appropriate patients. NIV is used in the management of patients with chronic obstructive pulmonary disease admitted to hospital with acute respiratory failure. There is a need for patients requiring NIV therapy to be treated by suitably competent staff which required an additional level of training. The ward had a non-invasive ventilation (NIV) specialist who trained nurses on the ward.

On the renal the ward manager and three of the four registered nurses had carried out specific training for dialysis, including a renal course at a local university. The fourth registered nurse had internal training with the renal education department and planned to attend the renal course at the university in 2019. All care support workers had also completed internal renal training sessions over a two month period.

**Multidisciplinary working**

*Staff in the multidisciplinary team worked together to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.*

All necessary staff were involved with the assessing, planning and delivery of patient care and we observed patients being discussed between specialities for advice on for example, specific care pathways. Staff told us that there was a strong multidisciplinary approach to patient care and that
communication between disciplines was effective and that they worked well together. Staff across the medical service, which included therapists and clinicians, worked together as a team to benefit patients. We observed several examples of good practice for multidisciplinary working during our inspection. On several wards we observed multidisciplinary team meetings in the form of a board round. These board rounds enabled holistic discussions and active discharge planning. Board rounds were generally completed at 8.30am each morning, and included consultants, therapy services including occupational therapy and physiotherapy, ward manager, matron and clinical navigator. The board included detailed information for each patient including acuity, VTE, MCA/BIA/DoLS, falls, pressure ulcers, section 2, section 5, referral, investigation, physiotherapy, occupational therapy, expected discharge date, completion of a discharge letter, whether take home medicines had been ordered, booked transport time, and whether the patient was able to be transferred to the discharge lounge.

A further multi-disciplinary team meeting was held at 12 noon which included the relevant social worker linked to the ward and therapy team and relevant updates were provided on the trust’s electronic patient tracking system.

Staff worked together on providing patient centred care and referred to specialist services where appropriate, for example to dieticians and speech and language therapists. We saw that patient records documented multidisciplinary team working across different professions. Some wards had a communication book to monitor all referrals to other healthcare professionals including the speech and language therapists, dietician and tissue viability nurse. A patient sticker was entered into the book with the date the referral was made and the reason for referral. Staff told us this was reviewed on a daily basis and if no contact had been made they would telephone the relevant person.

On Ashwell ward the frailty team worked closely together and consisted of a geriatric consultant, junior doctor and three frailty nurses. There were 14 beds on Ashwell dedicated to frail patients. Staff told us patients were triaged in the emergency department initially by the frailty team and then admitted to Ashwell ward. Patients were reviewed within four hours and staff told us they had seen a reduction in the number of patients being admitted from the emergency department unnecessarily, before other options for ongoing care had been explored.

Specialist nurses, for example in stroke, enhanced the multidisciplinary team by providing specialist training to staff, and inputting trust data into national audits such as SSNAP. They worked across care pathways, having involvement in the transient ischaemic attack (TIA) clinic and working closely with local community early supported discharge services.

The speech and language therapy team leader described how a nutrition multidisciplinary team had been set up to facilitate making dietary decisions based on holistic assessment.

We saw on the gastroenterology ward that not all nurses worked together as one team. During our inspection we highlighted an open store cupboard which contained consumable items, including stoma bags, and covers which could be accessed by members of the public. This was brought to the attention of nurses and the ward manager who told us the cupboard belonged to the specialist stoma team and therefore it was not their responsibility.

Staff told us they could access the Rapid Assessment, Interface and Discharge (RAID) team for support if patients had any mental health care issues.

Staff did report some concerns about the lack of access to psychology support. This was required to support patients to manage a lifelong illness as some patients develop anxiety and depression.

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or eating disorders as a result of trying to cope with a long term illness. There was only limited input available.

Seven-day services

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update, although this had recently been implemented and was still being embedded.

Acute medical services were available seven days a week including consultant cover, TIA clinic and the critical care outreach team.

There was medical consultant cover on AMU seven days a week. Nursing staff and junior doctors told us consultants were on-call out of hours and were accessible when required. On the care of the elderly wards that we visited, consultant ward rounds took place daily. Over the weekend, all new patients and deteriorating patients were seen by the on-call consultant with dedicated junior doctors for a detailed board round, assisted by a registrar. The patients on the acute cardiac unit (ACU) were seen daily by the cardiology consultant. Patients with a respiratory disorder were seen by the respiratory consultant seven days a week.

The diabetes outreach team provided a seven day service which provided advice and support Monday to Friday 9am to 5pm and Saturday to Sunday 8.30am to 12.30pm for new admissions. The team completed ward rounds identifying high-risk patients and worked with the relevant medical teams, as well as the patient to review and alter management plans. It also provided cross community and hospital working, with multidisciplinary teams. This meant patients could be tracked from one service to another to reduce any confusion in treatment plans.

Endoscopy was available 8am to 9pm Monday to Friday for inpatients and outpatients and on weekends from 8pm to 1pm for inpatients only. Staff told us inpatients would be seen on the day if the request was urgent.

Physiotherapy, occupational therapy and speech and language therapy services were available on the stroke ward over the weekend with an on-call respiratory physiotherapist available to cover all wards as required.

Health promotion

We saw a wide range of health promotion material available to patients during our inspection. There were posters displayed outside wards with contact details for smoking cessation services. The medical wards provided a range of health information leaflets for patients and relatives, including dementia UK, deep vein thrombosis, pressure ulcers; the tissue viability service, falls prevention in hospital and diabetes outreach team. The diabetes outreach team provided targeted information to patients around foot care, healthy diet and lifestyle choices. On the cardiology ward (ACU) there were British Heart Foundation information leaflets available for patients about heart disease, treatments and healthy lifestyle advice. There was a cardiac rehabilitation nurse in post who had a daily presence on the cardiac ward. She offered information and advice to patients on a one to one basis and attendance at a cardiac rehabilitation programme following discharge home.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Data for the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training was requested from the trust for the medical division. The data provided showed that 67.91% of medical staff and 94.52% of nursing staff had completed this training.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, data provided by the trust for mental capacity act training did not demonstrate good compliance with this training.

Staff we spoke with on all wards showed a good understanding of the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) processes. They were able to explain when capacity assessments may be required and the process for carrying these out and documenting them. Patient records that we reviewed showed that mental capacity assessment administration, best interest decision making and DoLS had been completed properly where appropriate. Completion of DoLS applications were made in a timely manner and staff followed this up with the local authority. On ward 9B we spoke to a matron who had a special interest in MCA and DoLS and acted as a specialist resource for staff on the ward by providing advice and support on the processes.

Staff told us that they received training in both dementia and learning disability awareness. Trust data showed that 394 nursing staff in the medical division had completed tier one dementia training. There was a tier two level training available for staff who regularly worked with patients with dementia. The trust were unable to provide data for numbers of staff who had completed tier two training. There was no target for compliance with dementia training and it was not a mandatory training subject. Staff had access to further information and guidance on the trusts intranet. Staff received support from the health liaison team to manage the needs of patients with a learning disability. Staff were able to refer to a learning disabilities nurse who was employed by a nearby community trust and worked within the acute hospital setting to support inpatients on the wards. The nurse was able to provide specialist advice on meeting the individual needs of patients with a learning disability. We saw that the team were piloting a purple star booklet to document recommendations made by the team which was kept with the patients nursing records.

During our inspection we observed incidences of implied consent when ward staff members took patient observations including their heart rate and blood pressure. Implied consent is when consent is not expressly granted by a person but implicitly granted by a person.

In the cardiac catheter laboratory staff were knowledgeable about the consent procedure and told us this started in outpatients through giving information and then consent was obtained from the patient on the day of their procedure. Patients confirmed procedures were discussed with them during their consultation where risks and benefits were explained and then written consent was sought on the day of the procedure.

Consent forms used were specific to the procedure being completed.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff members were courteous and helpful to patients and treated them with dignity and respect. Staff understood and respected patients’ social, cultural and religious needs and how these may relate to their care needs. This was reflected in the nursing assessment tools and documentation used. Staff introduced themselves and took time to interact in a considerate and sensitive manner. We observed staff speaking with patients in a respectful and considerate way. Most patients we spoke with were very complimentary about the care they had received and said staff were supportive of their needs.

On ward 9B we observed a caring and compassionate approach from a ward clerk who was able to speak in another language to a patient whose first language was that particular language. She spent time communicating with the patient to help them feel safe and understand their care. This demonstrated good understanding of their specific needs and a respectful approach to their care. We were told that on the same ward in January 2018, nursing staff had organised a wedding on the ward for a patient who was near the end of their life. This demonstrated that staff supported patients to express their views and be treated with kindness and compassion.

On ward 9A we saw that a CSW took time to sit with a distressed patient who was living with dementia; we observed them talking to the patient and holding their hand to provide reassurance. This demonstrated that staff showed a sensitive and supportive attitude to patients, taking account of their psychosocial as well as physical needs.

Most patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care. However, one patient said that during doctors ward rounds there was a breach of confidentiality as the conversations could be heard by other patients in the same bay. During our inspection we observed that there was a failure to maintain confidentiality during the nursing handover on one ward. This meant that staff did not always ensure that patients’ privacy and dignity needs were respected and maintained.

We saw that call bells were generally answered in a timely manner. Curtains were drawn, and privacy was respected when staff were supporting patients with personal care.

However, we observed one patient at mealtime who clearly appeared uncomfortable in their position and as a result was unable to eat. We noted that three staff members passed the patient without offering to provide assistance. We raised this with the ward manager and matron who immediately took action to assist the patient.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 47% which was better than the England average of 25% from December 2016 to November 2017.
Friends and family test response rates were displayed on information boards outside each ward. Staff told us that there was a target response rate of 40 responses per ward per month. However, on the SSU we saw that there had only been one response in February 2018. On ACU during February 2018 the target of 40 responses had been met and these showed that 97.5% of patients would recommend the service as a place to receive treatment.

The table below shows a breakdown by ward of numbers of responses, response rates and percentage of patients recommending the service as a place to receive treatment between December 2016 and November 2017.
Emotional support

Staff provided emotional support to patients to minimise their distress. Staff showed awareness of the emotional and social impact that a person’s care, treatment or condition would have on their well-being.

On Barley ward we observed a housekeeper reassuring an anxious patient about their discharge plans. She provided appropriate emotional support and informed the nurse in charge of the patient’s concerns so that possible additional support needs at home could be discussed with the patient prior to them going home.

Patients that we spoke with were positive about the support they received from the multidisciplinary team. Patients could access and be given appropriate and timely support and information to cope emotionally and mentally with their care or treatment. There was effective interaction with the mental health team, (rapid assessment, interface and discharge (RAID)) for patients who required support and assistance.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Most patients felt that staff communicated with them in a way which they could understand their care, treatment and condition. Staff communicated with patients in a way that was appropriate and respectful. We observed staff involving patients and those close to them during assessments on the ward. If the patients’ relative had any questions, staff were able to discuss these at the time.

We observed both medical and nursing staff taking time to involve patients during their assessments giving them time to ask questions or clarify comments. We saw evidence in care records that communication with the patient and relatives was consistent throughout the care pathway. Patients said they felt confident in asking staff and doctors for advice and told us they felt involved in their care.

Patients could access the services of interpreters and advocates to ensure patients understood the care and treatment being provided.

We observed therapists supporting and involving patients with their therapy on the wards that we visited.

We saw display boards outside all wards which provided details of support networks to enable people to improve their health and well-being, for example carer support groups and chaplaincy services. There was information about how relatives making regular visits to the hospital could access reduced car parking charges. There was a visitor’s charter and information about the 6 C’s so that relatives knew what standards of care to expect for patients. The 6 C’s (care, compassion, competence, communication, courage, and commitment) are a set of values that stand for the professional commitment to always deliver excellent care. There were notice boards displayed within each ward with photographs of each staff member and their name and role to assist patients and visitors in identifying who is involved in their care.

Staff told us that they used the “this is me” passport which is a booklet for all patients living with dementia. The booklet included space to detail a person’s cultural and family background; events, people and places from their lives; preferences, routines and their personality. It enabled health and social care professionals to see the person as an individual and deliver person-centred care that is tailored specifically to the person’s needs. Use of the passport can therefore help to reduce distress for the person with dementia and their carer and can help to overcome problems with communication.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Most patients admitted to AMU Blue and AMU Assessment were referred by their GP. The GP contacted the assessment unit where the call was triaged by a consultant. After 6pm the call was triaged by a medical registrar. Staff told us that the assessment units were designed to admit patients who were planned to have a length of stay of no longer than 48 hours. However, due to
winter pressures and increased demand of the hospital services, staff members told us that there were occasions when patients would stay for up to five days.

The trust provided a hyper-acute stroke service at the Lister hospital site. This enabled urgent assessment and treatment for all patients in the East and North Hertfordshire area and parts of Bedfordshire who had symptoms of a suspected stroke. This facility offered thrombolysis treatment 24 hours a day seven days a week. Thrombolysis involves special ‘clot busting’ medicines, alongside telemedicine technology to treat appropriate stroke patients. Studies have shown that this approach can save lives and give anyone suffering a stroke a better chance of making a faster and more complete recovery. In addition, the stroke service provided a seven day a week transient ischaemic attack (TIA)/stroke prevention clinic (a TIA is ‘mini stroke; caused by a temporary disruption of blood supply to the brain). TIA services provide rapid diagnostic assessment and access to specialist care for high risk patients thereby lowering the risk of a subsequent stroke. Patients with high risk TIA should be seen in a specialist TIA clinic within 24 hours of onset.

The trust’s cardiology team dealt with all conditions affecting the heart. It provided outpatient services in the cardiac centre and inpatient services were based in the acute cardiac unit. The cardiology service provided a primary percutaneous coronary intervention (PPCI) service in the cardiac catheter laboratory 24 hours a day, seven days a week, for patients suffering heart attacks. The inpatient cardiac ward (ACU) had been purpose built and offered a suitable environment for care of patients who were acutely unwell; it was bright and spacious. The cardiac catheter laboratory hours of operation for routine appointments, offered in outpatient clinics, was five days a week, Monday to Friday.

Acute medical services offered included a short stay unit (SSU) which was a 72 hour stay inpatient unit that worked closely with the emergency department, the acute medical unit and ambulatory care to admit patients who required a short stay to meet their care needs.

We were told about an acute kidney injury (AKI) team within medicine consisting of a consultant and specialist nurse who offered an outreach service across the hospital. They used nerve centre information and biochemistry results to identify patients with AKI and followed a treatment protocol based on a tool developed for management of AKI.

Patients were reviewed regularly by their named consultant and the medical team. Most patients saw their consultant or a senior member of the medical team daily. There was a ‘zoning’ system in place to ensure that medical outliers were tracked and regularly reviewed. In addition to the ward rounds, the nursing and medical teams conducted a “board round” whereby all patients were discussed with staff to review individual treatment plans and conditions. These meetings were completed daily in addition to ward rounds and were attended by all members of the multidisciplinary team (MDT).

Meeting people’s individual needs

The service took account of patients’ individual needs. There was additional support available for patients with a learning disability, living with dementia and those with mental health needs.

During our inspection we saw that information leaflets were available to provide more information about medical conditions and common investigations and procedures carried out. For example, in
the cardiac catheter laboratory we saw information leaflets such as ‘Your Coronary Angiogram’. These were provided to patients once an appointment for their diagnostic procedure had been given and provided details on the procedure and any information patients needed to know prior to the procedure. We also saw information leaflets were available at the rapid access chest pain clinic.

The medicine service had provisions and processes in place to keep male and female patients separate. This ensured there were no mixed sex breaches across the service. Patients were grouped according to their sex, and screens and curtains were used to maintain patients’ privacy and dignity. There were separate toilet and bathroom facilities for each sex.

Nursing staff had a clear understanding of the individual needs of vulnerable patients and had systems in place to promote safety and effective care. On SSU we saw white boards outside each bay which highlighted any special care or support needs of patients in that bay, for example the need for special diets or support required with eating and drinking. Staff told us that carers were encouraged to visit and support their relatives with feeding where appropriate. We observed that patients who were able to were offered support to sit out of bed at meal times. We observed mealtimes during the inspection and saw staff and carers supporting and assisting patients with their meals. Wards used red trays during mealtimes to help staff identify which patients needed extra attention when eating, or required foods that had a modified texture (such as mashed or pureed foods).

On ward 9A we saw that magnetic boards above patient bed spaces displayed various symbols to highlight any special support required. There were different symbols to represent the need for additional support with pressure care, mobility assistance needs, risk of falls, and dementia care. A “forget-me-not” flower was used as a symbol for people living with dementia. This was the equivalent of the ‘butterfly scheme’ which is a national scheme used to improve patient safety and well-being in hospitals. The scheme teaches staff to offer a positive and appropriate response to people with memory impairment. We were told that patients were asked to wear a yellow wristband with a forget-me-not blue flower symbol so that members of staff in the hospital could easily recognise and support that patient. This flower symbol was also placed above the patient’s bed to help identify those who may require additional help.

The ‘this is me’ passport was used to help identify the individual needs of patients with dementia. However, during inspection we identified six patients on one ward with a diagnosis of dementia and found that only two out of the six patients had the ‘this is me’ booklet completed by relatives. This meant that staff had not always sought accessible ways to communicate with patients and ensure that they were delivering person centred care.

We saw that most wards had red paintwork around toilet cubicle areas and red accessories in the toilet area to distinguish the toilet from the clinical white surroundings. This is known to be a dementia friendly technique as the colour contrast helps disorientated users more easily recognise the toilet area.

We were told that there was an enhanced nursing care team based at the Lister Hospital that supported patients with enhanced care needs across the hospital. They offered one-to-one nursing care to patients with dementia, delirium and other mental health challenges, which was prioritised based on their needs. The team consisted of care support worker (CSW) staff who had received additional training in dementia care, falls prevention, MCA and DoLS. We looked at the
records of four patients who had been referred to the enhanced nursing care team and saw that there were behavioural recording charts in place. However, two of these records had gaps in recording of up to six hours. We were told that this team were often difficult to access due to the high demand placed on it, although there were plans for additional recruitment to this team. Referrals were prioritised on the basis of greatest patient risk. If the team could not provide additional support, the wards told us that they used additional ward CSW staff to provide one to one care where necessary. There was a ‘bay watch’ initiative in place where patients with additional support or observation needs were cohorted into one bay which had an allocated member of staff supervising and supporting patients at all times.

On ward 9B we saw a reminiscence room with vintage memorabilia that was able to be used by patients at any time. There were weekly singalong and games sessions with afternoon tea, held in the room which were led by a carers lead.

Staff told us that the trust had a named Admiral nurse and had recently developed dementia champions roles. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. Dementia champions are existing ward staff who have received additional regular training and support in order to support both patients living with dementia, and staff, by promoting good practice in dementia care.

The trust could access learning disability support through the health liaison team employed by a local community trust. Staff referred to this team who aimed to assess patients within 24 hrs. The health liaison team’s role was to help adults with a learning disability to use health services. They provided expert support and advice to help people with a learning disability by obtaining the health care they needed by working with patients and staff. They supported communication difficulties, challenging behaviours, issues affecting capacity to consent and the need for specialist education of health care professionals. They provided information for health action plans in a document known as ‘my purple folder’. We were told of a particular example of how staff had supported an individual with learning disability needs on SSU. The MDT met and facilitated keeping the patient on SSU for several additional days over the usual 72 hour stay target, as they had become familiar with the ward environment and staff and it was felt it would be too distressing to the patient to move to another ward.

There was a dedicated mental health support team at the hospital known as the rapid assessment interface and discharge (RAID) team. The RAID team assessed and treated patients with dementia or other mental health problems, working closely with the clinical teams in the emergency department and on the wards. The Lister RAID team also worked with community mental health services and GPs to ensure that appropriate mental health treatment continued to be provided after discharge if required.

The trust supported John’s Campaign, a nationwide initiative for patients with dementia to have their carers and families welcomed into the hospital setting to be with them at any time. This enabled patients to have extra support from their carers during their stay in hospital, benefitting their health and well-being, and helped the carers’ support team to identify carers and provide them with extra support if they needed it. Nursing staff told us that visiting times were flexible to allow relatives of elderly patients or patients with a learning disability to maintain family contact during their stay in hospital in order to reduce distress.
There was a ‘Butterfly’ volunteer project in place which provided one-to-one companionship for dying patients who have few or no visitors to ensure no patient died alone. The team also supported families and carers, providing them with valuable respite whilst they care for loved ones.

We saw that there were posters displayed in ward areas which advertised that information was accessible in different formats. Staff members were able to request information in an accessible format for example large print, audio and easy read.

Access and flow

People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Average length of stay - Trust Level

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 1.7 days, which is lower than the England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than the England average of 6.6 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical oncology (previously radiotherapy) is lower than the England average.
- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.
Non-Elective Average Length of Stay – Trust Level

![Bar chart showing average length of stay for non-elective specialties.]

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in cardiology is lower than the England average.
- Average length of stay for non-elective patients in nephrology is higher than the England average.

Lister Hospital
From October 2016 to September 2017 the average length of stay for medical elective patients at Lister Hospital was 1.3 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than England average of 6.6 days.

Elective Average Length of Stay - Lister Hospital

![Bar chart showing average length of stay for elective specialties.]

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:
- Average length of stay for elective patients in cardiology, nephrology and gastroenterology are lower than the England averages.
Non-Elective Average Length of Stay - Lister Hospital

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in cardiology is lower than the England average.
- Average length of stay for non-elective patients in nephrology is higher than the England average.

Medical staff told us that there were routinely two consultants covering the acute medical service at the weekends supported by on-call registrars to ensure that patients received timely access to initial assessment, diagnosis and treatment.

During inspection we saw that the frailty team worked closely with Ashwell ward so that patients were reviewed within four hours. The frailty team consisted of a care of the elderly consultant, junior doctor and three frailty nurses and there were 14 beds on Ashwell dedicated to frail patients. Staff explained that patients were triaged in the emergency department initially by the frailty team and then admitted to Ashwell ward. Staff told us that through this process they had seen a reduction in the number of patients being admitted from the emergency department with an unnecessary admission.

There were regular and effective ward rounds and multidisciplinary team (MDT) board rounds which entailed holistic discussions to review the need for patients to remain in hospital and to facilitate active discharge planning as soon as appropriate. These board rounds involved medical and nursing staff, discharge coordinators, therapy staff and social workers.

The SSU had a target 72 hour stay for patients and generally admitted patients whose anticipated stay length was short or patients whose treatment pathway was unclear at the time of admission. Staff explained that they often struggled to keep within the 72 hour target stay and patients regularly stayed on SSU between four and six days. However, staff assured us that they worked closely with the emergency department (ED), AMU and ambulatory care to ensure that only the most appropriate patients were admitted and they told us that there was a constant focus on patient flow through the unit.

The trust had a discharge lounge which was usually located beside Ashwell ward, although the area could be used as an escalation area to relieve winter pressures. If this happened the discharge lounge facility was made available in a different area. The lounge was open Monday to Friday from 8am to 8pm. The discharge lounge sought to actively seek patients from the wards.
who were ready for discharge and waiting for medications or transport. Staff members told us that patients who were confused or likely to become disorientated, would not be transferred to the discharge lounge even if they were medically fit to be discharged as it may have caused them distress. We were told that the medicine division was the most frequent user of the facility. There were four beds and four chairs available. Staff told us that the lounge was underused and that they could manage increased numbers through the facility. Staff reported that they contacted the wards throughout the day to enquire if there were any patients who could leave the ward and wait in the lounge, thereby releasing a hospital bed. Staff were provided with lists of potential discharges by the bed managers which they used to help identify appropriate patients. The heads of nursing told us that there had been a recent initiative that aimed to increase the use of the discharge lounge. Wards had been encouraged to try and achieve a ‘gold discharge’ status for patients, which meant that a patient had arrived in the discharge lounge before 10am. Patients were suitable to stay in the lounge if they were medically fit for discharge and had their take home medication and discharge letters completed prior to arrival in the lounge. Staff told us that discharge letters did not always arrive with patients and that there could be a 24 hour delay in them being completed. We were told that in the event of such a delay the letters were sent on by fax to the patient’s GP surgery or care homes if required. Junior doctors cited difficulties with the new patient records system which had been implemented in September 2017 as the reason for the delayed discharge letters. On the day we visited, the discharge lounge was staffed by one registered nurse and one CSW although these were not staff who regularly worked in this area. We were told that there was not a dedicated team of staff working there, although the trust tried to use a ‘pool’ of regular staff who had experience of working in that area previously. We were told that the discharge lounge was staffed intermittently with through bank staff from NHS professionals. However, on the day we inspected there was a ward liaison clerk and a band five nurse from one of the surgical areas there. Although the ward liaison staff member had previously worked in the discharge lounge as a CSW, the registered nurse had never worked in the discharge lounge and had no experience of working with medical patients. Any medical care required was provided by the doctors on the ward patients had been discharged from, although emergency medical cover was available from neighbouring Ashwell ward if necessary.

There did not appear to be concerns around medications or transport impacting on the timeliness of discharges.

The trust used a green to red board system. Red days were identified if any planned action had not happened by the time specified, this included relevant investigations, referrals and if the expected discharge date had not been met.

Staff on ward 10B told us about a proactive project in place to further facilitate timely discharge. There was a 90 day quality improvement programme ongoing on ward 10B which had focused safety huddles on the ward to promote the ‘Red2Green’ approach. The Red2Green campaign is a visual management system from NHS Improvement to assist in the identification of wasted time in a patient’s journey. It is applicable to in-patient wards and was used to reduce internal and external delays. As a result of focusing on this approach, ward 10B had seen that discharges from the ward had doubled over the past two months.

Medical staff described how physician associate posts had been developed in partnership with a local university; these posts worked to educate nurses in care homes with the aim of preventing unnecessary hospital admissions. This was a good example of an initiative to manage patient flow.
During the inspection we were told of some concerns with reduced availability of community services which impacted on timely discharge. Staff told us that there was reduced access to social care home care packages due to lack of capacity within the social care sector to assess for, and provide, care packages. Staff also reported delays in accessing residential home placements for eligible patients due to lack of available funded places. There were limited community rehabilitation services for complex patients such as stroke patients who required continued therapy after being discharged home. Community early supported discharge services (ESD) for stroke were available for patients registered with a Hertfordshire GP. This meant that there were some stroke patients admitted to the East and North Hertfordshire hyper-acute stroke unit (HASU), which is a regional HASU, who did not meet the eligibility criteria for this service. There were also limited community rehabilitation services for more complex stroke patients who did not meet the ESD criteria of being able to transfer with one. Rehabilitation beds were available but were difficult to access due to the slow flow through them. This potentially resulted in delayed discharge of some stroke patients.

The trust strived to offer appointments for outpatient medical procedures in a timely way. We were told that cardiology patients were given a date for elective diagnostic procedures within six weeks of referral.

The trust strived to keep the number of bed moves per patient during an in-patient stay to a minimum. There was a trust wide bed management policy which stated that bed moves during patient stays should be minimised and should be no more than three, less for patients living with dementia. We saw that there was a checklist to complete prior to patients moving beds which assessed if patients were suitable to be moved by assessing them against criteria. The policy stated that any unavoidable bed moves should happen before 10pm and that a log should be kept of any bed moves that happened between 10pm and 7am. These situations would then be incident reported and investigated.

Staff told us that they did not move acutely unwell patients or patients who were disorientated, for example those with dementia or delirium, unless absolutely necessary. They reported that bed moves late at night were avoided, although most acute medical wards accepted admissions to the ward at any time of day or night.

We were told that there was a need for some medical patients to be outlied on other wards due to a lack of bed capacity, although there was a clear policy to follow for this. During our inspection we found that there were seven medical outliers on a surgical ward. There was a clear process in place for tracking outlying patients and doctors told us that this worked well. Outliers were discussed at the daily medical handover meetings to ensure staff knew which wards patients had been moved to, in order that they could be reviewed. We saw a copy of a report produced for the risk and quality committee in November 2017 which recommended the use of zoning outlier patients. During our inspection we found that the zoning system had been implemented; zoning was where patients were grouped by consultant/specialty who had designated wards where their patients would be sent to. This ensured that medical cover for outliers could be organised and consistent care could continue to be provided to all medical patients. We reviewed two sets of medical records on a surgical ward which had medical outliers. Records confirmed patients were seen by a medical doctor (who was a senior decision maker) daily. We spoke with medical doctors who confirmed outliers were identified through the bed manager, the emergency department and the medical ward they were linked to, which ensured patients were seen as part of their usual ward round.
There were 15 escalation beds used for periods of excess demand, for example, winter pressures. These were located on ward 7A and the discharge lounge was also used for additional capacity if required. Heads of nursing reported that there was a comprehensive winter pressures plan in place and that although there had been capacity issues they had been managed through the plan. When escalation beds were in use bed management meetings happened at 9am, midday, 3pm and 5pm daily. There was a social media group for heads of nursing and matrons which enabled regular communication about the management of the escalation beds.

Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2016 to August 2017 the trust’s performance was similar to the national average. The chart shows no data since September 2017 which was when the trust rolled out a new patient administration system. This has affected some data submission.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average for admitted RTT (percentage within 18 weeks).

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<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>97.8%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>94.6%</td>
<td>94%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>93.8%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Four 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>General Medicine</td>
<td>88.9%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.9%</td>
</tr>
</tbody>
</table>
The trust scored 0% for referral to treatment within 18 weeks for rheumatology, dermatology and neurology.

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

There was a trust wide approach to managing complaints with the director of nursing having overall responsibility for the complaints process. There was a head of complaints who had day to day responsibility for managing complaints and was supported by a team of patient advice and liaison service (PALS) case handlers, a senior complaints officer and complaints assistant. There was an internal trust target for acknowledging complaints within three days which had 100% compliance. The target for completing a complaint was 30 days which was 80% compliant. ‘Completing’ was defined as closing the complaint when it had either been resolved or it was decided that no further action could be taken. Complaints were reviewed in a range of forums including:

- monthly & quarterly risk & quality committee
- divisional boards
- rolling half days
- clinical governance
- divisional senior management team
- data provided for nursing quality metrics, and key performance indicators
- patient experience committee

The process for handling complaints was, if it involved medical care and related to aspects of care undertaken by a member of the medical team, for the case handler to send it to the consultant who had overall responsibility for the care of the patient. The consultant managed the complaint. If the complaint was about the consultants attitude and/or practice it was managed by the clinical director for the medical division. As part of this process, there was a requirement for the medical director to provide statements of discussions held with staff and to provide evidence that a review of the medical records had been undertaken.

The relevant ward manager was allocated all nursing complaints and the same process was followed. If the complaint was about the ward manager it was managed by the matron. All complaints were copied to general managers and deputy general managers, divisional directors, clinical directors, heads of nursing, divisional chair and the consultant. We saw that the division kept a complaints tracker which was managed by the heads of nursing. This was a spreadsheet which logged all complaints detailing the issue, the ward, date and complaint outcome. This enabled senior staff to have an oversight of complaints, monitor them for any themes and ensure they were managed in accordance with trust policy.
Staff were knowledgeable about the complaints process and informed us they would be contacted by the central complaints team when a complaint was made. Ward staff were involved in the investigation into complaints to ensure that all information was available. Following this, a response was sent to the central complaints team who devised a letter for the complainant. All final complaint responses were signed off by the Chief Executive Officer.

Learning was disseminated through reports presented at various clinical and non-clinical forums. Each area was expected to complete action plans in order that there was learning from complaints. In addition, complaints were discussed in ward team meetings to ensure that learning was disseminated to all staff groups and not just those who have been cited in a complaint. Staff and ward managers confirmed that this happened.

We saw that the trust displayed “You said we did” posters on the information boards outside the wards which included complaint outcomes and highlighted any changes made in response to complaints. For example, we saw that new pillows had been bought for ACU in response to a complaint about insufficient pillows being available for patient comfort.

Posters and leaflets were displayed throughout the hospital and there was a PALS office located centrally in the main corridor of the hospital, which was open Monday to Friday during the hours of 9am to 4pm. Out of hours there was a sign on the door informing patients/relatives/carers to speak with the main reception who would contact the on-site matron/manager for assistance. We saw contact details of how to contact PALS and information about how to make a complaint and how complaints are handled on each ward we visited. The trust website provided information on how to raise complaints and concerns. There was a capability on the trust’s website that translated PALS information into numerous different languages with one click. In addition, easy read leaflets were available. Patient feedback was encouraged through social media. The trust’s general enquiries team encouraged patients/relatives to contact PALS, in the first instance and provided details of the formal complaints process when required.

Staff were encouraged to try to resolve minor complaints verbally “on the spot”. Staff we spoke with explained how they listened to patients concerns and tried to resolve their concerns by showing understanding and apologising where necessary. However, they were aware of the escalation process in the event that they were unable to achieve a satisfactory immediate resolution. In this situation staff described how they would explain the role of PALS or make contact with PALS themselves for advice and support.

Summary of complaints
From November 2016 to November 2017 there were 122 complaints about medicine. The trust took an average of 38.9 days to investigate and close these complaints. This is not in line with their complaints policy, which states complaints should be closed in 30 days of receipt of the complaint.

Complaint breakdown by site:
- **Lister Hospital**: There were 109 complaints which took an average of 38.9 days to complete and close.

These were most commonly in relation to treatment received.
The Trust told us that they had received 97 complaints in February 2018, 27 of which related to medicine. The graph below shows a breakdown of these complaints by ward and theme:

![Complaints Breakdown Graph]

There is a national mandatory timeframe of acknowledging receipt of a formal complaint within three working days. The trust reported that this was achieved in February 2018 with 100% of complaints being acknowledged within the timeframe.

The Trust has set a target of 80% of all open complaints across the divisions being formally responded to within the agreed timescale with the complainant, per month. In February 2018, 75% of all the open complaints in the medicine division were responded to within the agreed timescale.

During the inspection we saw that on Ashwell ward a total of 14 complaints had been received between January 2017 and February 2018. We noted that 10 of these related to quality of care, specifically delayed discharges due to packages of social care not being re-started in time, transport and medication to take home. Three complaints were regarding communication and one was regarding attitude of a staff member.

We saw an example of when duty of candour had been applied following a complaint in the cardiology department. A patient had to wait excessively to be seen by a consultant and for their scan results to be reviewed and during this time period suffered a cardiac arrest. We found that a written apology had been issued to the patient and that this was an open and honest acceptance of staff failure to provide an appropriate level of service. We saw that an action plan had been put in place to prevent a similar situation recurring.
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run the service. There were clear lines of accountability within the divisional leadership team.

The medical division was led by a triumvirate of four senior members of staff; the divisional chair, two deputy divisional chairs and a divisional director. We were told that this senior team met together weekly and had bimonthly meetings with the rest of the trust’s senior management team.

There were clear lines of accountability within the divisional leadership team. The divisional chair and divisional director reported to the chief operating officer. The deputy divisional chairs, medical director and clinical directors, all reported directly to the divisional chair.

Heads of nursing reported to both the divisional director, and the director of nursing. There were two heads of nursing; one who led the emergency and acute medical services and another who led the medical specialty services. The heads of nursing attended the divisional governance meetings and nurse specific meetings with the director of nursing including patient safety, and infection prevention and control meetings.

Nursing staff reported that there was strong local leadership on the wards and that matrons and ward managers were both visible and supportive. They told us that they felt supported by the local management team. However, they told us that they rarely saw members of the senior executive team such as the director of nursing or chief executive and not all staff knew the names of these post holders.

The trust had a leadership programme in place known as ‘LEND’ - listen, empower, nurture, develop. This was a leadership, coaching and development pathway for aspiring, new and experienced leaders from all staff groups. The pathway offered a comprehensive set of leadership programmes that covered all staff groups at all levels. The programme targeted different sessions at different levels of staff and covered a broad range of topics including supervisory skills, leadership attributes, quality and service improvement, and finance. The programme was available to staff with little or no management responsibilities at bands one to five (aspiring leaders) through to an accelerated director development scheme for more senior staff who were already working in leadership roles. The trust had a vision to develop the capability and capacity of the workforce to influence and inspire a culture in which compassion and effectiveness drove continual improvement. We spoke to several staff across a range of grades who told us they had accessed the LEND programme and found it relevant and useful to their role.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The medical division had developed a strategy which aligned to the trust’s five year strategy by focusing on patient pathways to provide ‘the right care, in the right place, first time’. The medical
leads told us that they were striving for best patient care for all patients at all times in order to improve patients’ outcomes. In order to achieve this they explained that there was a strategic development of key services such as renal and diabetes services. The division had a vision to have no serious incidents during the next 18 months which they told us could only be achieved if patient pathways were developed. We were told that the medical strategy was refreshed every two years and was currently undergoing this process and was in draft format. Key stakeholders including lead nurses, clinical directors and the divisional senior management team were involved in this process. We requested a copy of the draft strategy following our inspection and were provided with a document entitled ‘draft divisional summary of medicine strategy’, dated 12 April 2018. We were told that the full document was still under development. The draft summary identified the priorities for the division, highlighting patient safety, staff recruitment and retention, service improvements, patient access to services (particularly ED), and value for money as the focus of the draft strategy.

The vision and strategy for the trust were on display in each of the wards we inspected. Most but not all staff we spoke to were aware of the trust values.

**Culture**

**Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

There was a culture of collective responsibility between teams and services. Staff felt listened to and said they worked well together as a team. There was a strong culture for delivering high-quality care. Most staff felt valued and respected in their roles and supported to deliver care to the best of their ability. They said managers were approachable. Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns to managers without fear of retribution. However, staff were unable to describe the process for escalating serious concerns, without fear of retribution, known as whistleblowing. No staff we spoke with were able to name the freedom to speak up guardian for the trust and generally did not know that the role existed or what its purpose was.

Staff told us there was good communication in the team and felt supported by their line managers. Across all areas staff said they were committed and passionate about the care they provided to patients. They reported feeling proud to work in the trust and felt positive about the job they did. There was an award system in place which had recently been developed and offered monthly recognition of staff achievements. There were awards for best team, best individual and continuous improvement.

Staff we spoke with reported feeling respected and valued by both managers and their peers. Staff did not express any concerns about bullying or harassment.

The trust values underpinned a positive culture by emphasising the expectation of staff being open and honest, valuing everybody and working as a team. The first value of putting patients first also promoted a patient-centred culture within the trust.

There was a support service in place available to all staff which staff told us was a valued staff benefit. The employee relation advice service offered the opportunity to speak in confidence and receive support and counselling for both work and non-work-related issues.
There were good systems for performance reviews for staff. Staff felt action was taken to address behaviour and performance when necessary regardless of seniority, for example, when behaviour was inconsistent with the vision and values.

**Governance**

*The service did not use a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.*

There were clear lines of accountability including clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line.

There were effective processes and systems of accountability. Staff were clear about their roles and what they were accountable for. The divisional leads (known as the triumvirate) held governance meetings twice a month where serious incidents and incidents within the medical division were discussed. We requested the minutes of the last six months of divisional governance meetings. We were informed that the minutes for the meeting in February 2018 were not available and were provided with the minutes from November and December 2017 only. It was unclear which division the meetings related to and we found that the two meetings had different titles. The records of the meetings were brief notes and it was unclear what level of information was discussed. There was no attendance list for these meetings. Notes did not always identify who the responsible person was for actions.

The triumvirate also attended clinical strategy meetings and divisional board meetings which both happened every month. We saw minutes of these meetings indicating there was a focused agenda which reviewed all areas of performance and risk and identified priorities for action. There was always a ‘good news’ section within these meetings. Key information from these meetings was sent to all staff by email as a ‘message of the week’. A monthly clinical governance letter was sent to all ward leads. We were told that exception reporting meetings were held with speciality leads every two months, in order to review the division’s performance against key performance indicators. Any areas of concern were then escalated to the divisional exception committee (DEC). We saw copies of reports submitted to the DEC which identified any key areas for concern including, issues with performance, divisional risks, serious incidents, complaints, staffing, and finance.

We were told that the medical division leads and matrons met fortnightly. We asked to see minutes of these meetings but were told there was no formal process in place to record the discussions of these meetings. We were not assured the division adequately discussed or had complete oversight of the clinical governance agenda.

The heads of nursing and ward managers demonstrated awareness of governance arrangements. They described the actions taken to monitor patient safety and risk. This included monitoring risk dashboards, incident reporting and undertaking audits. The heads of nursing met monthly with the matrons and ward managers at a leads meeting where incidents, risks and development ideas were discussed. These meetings were chaired by the director of nursing. Thematic reviews of incidents completed by the matrons were presented at this meeting and presented to the board.
There were monthly team meetings on most, but not all, wards for all staff where complaints, incidents and the learning from these were discussed. Staff told us information was disseminated to them in team meetings including updates on service developments. Staff told us they felt they were able to contribute to these meetings including putting forward ideas for improvements. However, ward 7A staff informed us they did not have regular updates from the ward or from trust level. They informed us the only updates they received were regarding patient care during handovers at the beginning and end of each shift.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the division’s mandatory training rates were below the trust’s target. This had been the subject of a requirement notice at the last inspection and there had been little improvement.

The divisional leads for medicine highlighted three risks which scored most highly on the divisional risk register; these were:

- A lack of inpatient capacity and resultant impact on patient flow (score 25)
- Staffing level concerns (score 20)
- Impact of recent introduction of electronic patient record system and a software system which used technology to record and monitor patient observations via mobile devices (score 20)

Risks were scored on a risk assessment 5x5 risk profiling matrix (likelihood versus consequence), where the highest possible score was 25. Key risks were regularly discussed at governance meetings and mitigating actions were implemented where possible. For example, a stabilisation programme had been put in place following the inability to manage patient tracking lists after the changes to the patient records system. In addition there had been a recruitment drive to address the staffing issues and over 50 extra nursing staff had been recruited in the last year to mitigate the staffing risk. The risks highlighted by the divisional leads were consistent with the ‘worries’ and risks that staff highlighted to us during inspection. The main risk cited by ward staff was staffing, and ward managers and doctors reported concerns relating to the new patient administration system. On Ashwell ward the matron and ward manager told us the biggest risks to their areas were the increased number of beds, as during our inspection the ward had an additional four escalation beds. We were told that the additional four beds were added as one bed per bay and impacted on the accessibility of immediate hand wash facilities. However, the bays were set up for the extra beds and provided all appropriate patient care facilities around each bed area.

The risk register was reviewed regularly and contained description of the risk, ratings and controls in place, gaps in control, assurances and action plan. Managers and senior staff were aware of the risks in their individual service areas. All risks stated by managerial staff during the inspection were reflected on the divisional risk register.

Clinical and internal audit systems were overseen by the divisional deputy chair who had responsibility for monitoring the division’s audit programme. Audit outcomes and performance reviews were presented at the divisional board meetings and escalated through the divisional exception committee when there were any performance concerns. The divisional deputy chair also
had responsibility for monthly performance reviews. We were told that almost all key performance indicators were regularly met. We saw that the monthly exception reports produced by each specialty within the division monitored and reviewed performance against key performance indicators; these were discussed at the divisional exception committee meetings.

The heads of nursing explained that there was a winter pressures plan in place that had been implemented in December 2017 due to capacity issues. They described the plan as robust and working better than in previous years. The plan included the opening of escalation beds which were managed alongside the rest of the division’s bed capacity through regular bed meetings held four times a day. We were told that during the winter when activity was increased, the discharge lounge was used as an escalation area with five beds which Ashwell ward was responsible for. As part of the winter pressures planning there was a social media closed group created to improve communication between the matrons and heads of nursing. The winter pressures plan was a trust wide plan which required the medicine division heads to work closely with the heads of other services.

There was a cost improvement plan in place for the trust although the division worked hard to ensure that this did not impact negatively on patient care. The trust had implemented a financial management process termed ‘grip and control’ to help meet cost improvement plan requirements. The divisional directors told us that any service improvements requiring financial support went through the grip and control process and that this could cause a three to six month delay in implementing service improvements. For example, a need for improving access to diabetic foot checks had been identified but the request for funding for extra capacity was still awaiting approval several months later.

There was a need to relocate the haemodialysis unit based at Luton and Dunstable hospital since notice had been served on the current premises. The cost of alternative premises to deliver this service was anticipated to be high and was a concern that had been raised on the divisional risk register.

**Information management**

**The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.**

Audit data was reviewed at clinical speciality and divisional level meetings. This meant that there was a service awareness of performance. The divisional directors had oversight of all specialties within their division and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service.

There had been a recent innovation to use telemedicine within the division. Telemedicine had been used to support patients to have dialysis at home and to improve self-management in young diabetic patients. Telemedicine allows health care professionals to evaluate, diagnose and treat patients at a distance using telecommunications technology. This innovation was generated by a staff idea and was implemented in consultation with patients using the service. It had resulted in some patients reducing the number of hospital appointments they needed to attend which meant they needed to take less time off work.
The division used a software system to provide financial information alongside the reference cost index metrics which measured effectiveness of care delivery against national benchmarks. Dr Foster data, SHMI and HSMR data were routinely used to monitor performance and review performance against other trusts.

**Engagement**

*The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services effectively.*

The ward displayed information for patients and their families about ways in which they could comment on their experiences in a confidential setting, such as through accessing the patient advice and liaison service. We saw that the division produced monthly patient experience action plans for discussion at the patient experience committee meetings. These plans identified the division’s achievements in improving patient experience as well as the challenges that impacted on this. Ambitions were set around improving the patient experience and a risk matrix evidenced achievement against these ambitions including outstanding actions, named leads for actions and timescales.

Staff said they felt able to share concerns and feedback with managers as they were often on the ward and the ward manager was often working alongside them.

We were told about an innovation on Barley ward that was a result of collaboration between staff, patients and relatives to improve the patient experience. Ward staff initiated a forum for patients and carers to share feedback about care, behaviours and outcomes that they would always expect during their inpatient stay. This information was shared to create a charter of ‘always events’ that detailed what patients should expect during their hospital stay.

One of the heads of nursing explained that she was chair of a nutrition and hydration group that had used patient feedback through a focus group to implement improvements in meal services including the introduction of snack boxes.

The divisional leads told us that the most recent staff survey results had raised some concerns around staff behaviours, including reference to bullying and low staff morale. The results had not been disseminated to staff and action plans for addressing the concerns were being considered. We saw a copy of the 2017 staff survey report which showed that in the medicine division the staff engagement score was 3.66 (where 1 is low and 5 is high); this score indicates how likely staff were to recommend the trust as a place to work or receive treatment. This was the highest engagement score reported across the different divisions. However, 32% of staff reported they had experienced harassment, bullying or abuse from staff within the last 12 months; this was the highest reported figure across the different divisions.

We were told that the division did not complete local staff surveys although they had previously held focus groups to gather staff feedback. Up until recently staff ‘coffee and chat’ sessions were held within the division to listen to staff views but these had been stopped due to capacity issues. There was, however, a weekly meeting with junior doctors to encourage feedback and to ensure that staff were fully aware of the impact of their actions on the patient care pathway.
Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There was active participation in research throughout the medical division. Research nurses for diabetes, stroke and cardiology had a daily presence on the wards and sought to recruit patients to a range of national research studies. There were also examples of service improvements and innovations, for example:

- The diabetes outreach team were sharing information with Diabetes UK around the use of clinical assistants providing a structured educational programme for patients. They had evidence that the programme assisted with patient experience and care which was being shared nationally through their work with Diabetes UK.

- The frailty team had been working with a local charity and emergency services to implement an immediate alert for patients discharged with a do not attempt cardiopulmonary resuscitation (DNACPR) or advance notice in place. When a patient was discharged they were given a distinctive bottle, with a sticker of the charity’s logo on, which contained a copy of their DNACPR. The bottle was placed in the patient’s fridge when they arrived home and a similar sticker was put on the patients’ fridge door. This meant that in an emergency situation, the emergency responders would know on arrival to look inside the patient’s fridge for a DNACPR document. The frailty service had plans to extend this into the community working with residential and nursing homes. However, the implementation was in the early stages and plans were in place to audit its effectiveness in the future.

There was a commitment to ongoing learning and continued professional development within the division. For example, there was a foundation programme for middle grade doctors who received educational appraisal from consultants and there were awards for academic posters produced, best trainer and best trainee.

There was an effective process for regular mortality reviews where issues were raised at division specialty meetings for discussion and to ensure learning; these meetings were minuted and we saw copies of these which evidenced comprehensive review of mortalities and morbidities with learning identified and action plans for improvement. The meetings were held as a rolling half day platform for sharing learning from mortality reviews which was open to all staff. In order for this meeting to have quorate attendance, a minimum of a medicine, nursing and junior doctor representative needed to be present.

A monthly staff award system had been put in place following the last trust staff survey. These awards were known as star awards and were awarded to both individuals and teams in recognition of achievements and service improvements. This recognition system aimed to drive improvements across the trust.
Surgery

Facts and data about this service

The trust provides inpatient surgical treatment at Lister Hospital, Stevenage. The trust has 12 surgical wards with a total of 235 inpatient beds, the surgical assessment unit ward has 10 side rooms, eight ambulatory spaces and one clinic room, 17 operating theatres and the post anaesthetic care unit (PACU) has 26 cubicles.

(Source: Routine Provider Information Request (RPIR) – Acute-Sites)

We inspected surgical services from 20 to 22 March and 3 April 2018. As part of the inspection, we visited the pre-operative assessment clinics, the day surgery unit, the main operating theatres and the operating theatres in the treatment centre, the recovery area, and all the surgical wards including 5A, 5B, 7A, 7B, and 11A, plus the surgical assessment unit. Surgical services provision at Lister Hospital includes general surgery, trauma and orthopaedics, ear nose and throat surgery, plastic surgery and urology.

The trust had 32,527 surgical admissions from September 2016 to August 2017. Emergency admissions accounted for 11,155 (34.3%), 15,461 (47.5%) were day case, and the remaining 5,911 (18.2%) were elective.

(Source: Hospital Episode Statistics)

During the inspection, we spoke with 35 staff of various grades, including ward and theatre managers, nurses, therapists, consultants, junior doctors, healthcare assistants, and housekeepers. We spoke with 16 patients and their families and observed care and treatment. We looked at 31 patient’s medical records and 20 medication charts.

The service was last inspected in October 2015. At that inspection, the surgical service was rated good for all five domains.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. There were some areas of poor compliance with mandatory training including fire training, basic life support and information governance. We also found theatre staff did not have the appropriate level of advanced life support training (ALS).

Following our previous inspection, we recommended that the trust set target levels for mandatory training and that further training should be provided. During this inspection senior ward staff, told us that training was linked to incremental pay incentives to improve compliance rates. This meant
that if staff did not attend training, it affected their salary. However, it was clear that once staff reached the top of their incremental band, compliance rates decreased. This was because at this stage, not attending training did not affect their salary.

The trust set a target of 90% for completion of mandatory training. Below is the data for medical and dental staff, nursing and midwifery within the surgical division at the Trust from April to October 2017.

Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>214</td>
<td>285</td>
<td>75.1%</td>
<td>90%</td>
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</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical</td>
<td>213</td>
<td>285</td>
<td>74.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>(including management of inoculation injuries &amp; hand hygiene)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>213</td>
<td>285</td>
<td>74.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>213</td>
<td>285</td>
<td>74.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>176</td>
<td>285</td>
<td>61.8%</td>
<td>90%</td>
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<tr>
<td>Fire Safety - 1 Year</td>
<td>175</td>
<td>285</td>
<td>61.4%</td>
<td>90%</td>
<td>No</td>
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<tr>
<td>Information Governance - 1 Year</td>
<td>129</td>
<td>285</td>
<td>45.3%</td>
<td>90%</td>
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</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 66.8%. Of the seven mandatory training courses delivered by the trust to medical and dental staff, none met the completion rate target of 90%.

Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
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<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>345</td>
<td>370</td>
<td>93.2%</td>
<td>90%</td>
<td>Yes</td>
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<tr>
<td>Infection Prevention &amp; Control-Clinical</td>
<td>341</td>
<td>370</td>
<td>92.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(including management of inoculation injuries &amp; hand hygiene)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>341</td>
<td>370</td>
<td>92.2%</td>
<td>90%</td>
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<tr>
<td>Mandatory Training</td>
<td>Total Completers</td>
<td>Total Attendees</td>
<td>Completion Rate</td>
<td>Target</td>
<td>Met Target</td>
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<tr>
<td>Conflict Resolution - 2 Years</td>
<td>340</td>
<td>370</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>325</td>
<td>365</td>
<td>89.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>321</td>
<td>370</td>
<td>86.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>311</td>
<td>370</td>
<td>84.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>286</td>
<td>370</td>
<td>77.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff was 88.3%. Of the eight mandatory training courses delivered by the trust to nursing and midwifery staff, four met the completion rate target of 90%.

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

Most staff told us that the training was available and provided the required knowledge. However, senior nurses told us that they found it difficult to allocate staff to training due to staffing demands and ward pressures.

During our inspection, we spoke with staff regarding mandatory training. Staff were responsible for booking and completing their own mandatory training. However, ward managers told us that they were monitoring compliance and reminding staff about completing mandatory training. We saw on wards 7B, 8B, and 11B that the ward managers had completed a training matrix in order to ensure all training and appraisals were completed within the required timescales.

Staff received additional training to the mandatory topics depending on their role. For example, ward 11B staff (plastics and ear nose and throat ward) had advanced airway and tracheostomy training. The link nurse for airway management had attended an advanced airway management course in London for three months, so that they could provide training sessions to ward staff. However, we did not see evidence of the individual staff training competencies therefore; we could not be assured that relevant training had been completed.

Staff completed mandatory training in dealing with medical emergencies such as basic life support (BLS). Compliance for BLS training for staff within the surgical division was 77.4%, which was 12.6% lower than the trust target of 90%.

Nursing staff within the operating theatres told us, they were not trained in advanced life support (ALS) and not all staff had received intermediate life support training (ILS) however, all staff had completed basic life support, which included automatic external defibrillation (AED) training. The Association of Anaesthetists of Great Britain and Ireland recommend that all specialist staff within anaesthetics and theatre recovery areas have appropriate training in advanced life support (ALS). This meant that not all specialist theatre staff were trained to the appropriate level.

Staff on the surgical wards said they had not received training for screening and application of a sepsis protocol, which was confirmed by the surgical matron. Sepsis is a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs. This meant that a patient with sepsis could be missed and appropriate action not taken.

Nurse staff training was not always recorded and some training provided was informal. For example, experienced nurses demonstrated how to work some medical devices and equipment to
junior staff. However, there was no competency assessment follow up and records of the training were not always made. Medical device training was not always documented and updated in line with trust policy. Medical devices include, medication pumps, vital signs monitoring equipment and bladder scanning machines. Trust policy stated that ward managers must keep a record of staffs’ annual self-assessments; this compliance was to be monitored by the matrons. However, we saw no evidence of this from the ward managers or matrons during our visit.

Staff told us that if they required a medical device they would collect equipment from the equipment library. Receipt of the equipment could only be obtained if the staff member signed to confirm training competencies had been completed. Initial training and competencies were carried out by the medical device trainers during study sessions. The competent nurses would then cascade the information required to use the medical device proficiently to the staff that required training, in line with manufacturer’s guidelines.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most nursing staff had received training on how to recognise and report avoidable abuse and they knew how to apply it. However, medical staff training compliance was 70%. In addition, staff working within the surgical division who were caring for young people under the age of 18 years did not have the correct level of training.

**Safeguarding training completion rates**

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

A breakdown of compliance for safeguarding courses from April to October 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

**Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>196</td>
<td>277</td>
<td>70.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>197</td>
<td>280</td>
<td>70.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>199</td>
<td>285</td>
<td>69.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>199</td>
<td>285</td>
<td>69.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall medical safeguarding training completion rate was 70.2%. The trust did not meet the completion rate target for any of the safeguarding modules it delivered.
The trust's overall nursing safeguarding training completion rate was 92.2%. The trust met the completion rate target for all four of the safeguarding modules it delivered.
(Source: Trust Provider Information Request P18)

Staff understood how to protect patients from potential abuse. They were aware of their responsibilities to report safeguarding concerns and knew whom to contact for advice. Staff described examples of when they would raise a safeguarding concern and knew what actions to take to protect vulnerable adults and children. Staff knew how to find out who the safeguarding leads were within the trust. Mandatory training levels for surgical services were below the trust's target of 90% in levels one and two for safeguarding adults and children.

Surgery - safeguarding compliance for L1 and L2

<table>
<thead>
<tr>
<th></th>
<th>January 2018</th>
<th>February 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>Level 2</td>
<td>89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Source- additional evidence request- DR 333)

Staff within the surgery division had not completed safeguarding level 3 training. The trust told us that no level 3 training was required within the surgical division. The Intercollegiate document for safeguarding children and young people advises that level 3 clinical training should be provided to staff working with children, young people and/or their parents/carers if they are potentially contributing to assessing, planning, intervening and evaluating the needs of a child or young person.

However, during our inspection staff we spoke with told us that patients between the ages of 16 - 18 years of age were given the choice as to where they would like to be nursed. This meant that 16-18 years old could be treated on adult wards where the nurses had not received appropriate safeguarding training.

Staff within the theatre departments routinely cared for patients under the age of 18; level 3 safeguarding training had not been completed by any theatre staff. The trust informed us that there was a lead anaesthetist with level 3 compliance in safeguarding, but this member of staff...
was not present in theatres at all times when a young person was in the operating theatre or recovery.

The trust provided staff with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) within the mandatory safeguarding training, which was provided at induction, with updates every two years. We were told that 94% of nurses were compliant in this training and that 75% of medical staff were compliant. However, ward staff including ward managers told us that they had not undergone the training and were not able to explain the steps in assessing DoLS, as it was not used often on the surgical wards. Four senior nurses within the trust had completed the best interest’s assessor training. This provided knowledge available to guide and advise staff within the trust.

Prevent awareness training, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, was included within the adult safeguarding training. However, staff were unable to discuss this training and were not aware that it had been completed. Prevent awareness training compliance within the surgical division was 88.9% for all staff and 90.4% for clinical staff (NHS England target 85 %).

Prevent level 3 training within the surgical division was at 18%. The trust acknowledged this was low and actions had been put in place to improve this.

The clinical staff we spoke with on the surgical wards could not tell us if they had received training regarding, female genital mutilation (FGM). The World Health Organisation defines FGM as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

**Cleanliness, infection control and hygiene**

The service did not control infection risk well in all areas. Staff did not always keep themselves and equipment clean, although some control measures were in place to prevent the spread of infection.

During our inspection in October 2015, we found the environment to be clean and most staff followed the trust policy on infection prevention and control. There were variable cleaning schedules within the wards and theatres. Some wards did not have dedicated cleaning schedules for both the environment and equipment. On this inspection, we found there were no cleaning schedules in place on the surgical ward areas. Each ward stated that they performed cleaning routines; however, we did not see any documented evidence to support this. Swift ward however, signed and dated on the back of the patient doors that cleaning had been completed.

Hand hygiene practices within the service were not in line with national and local policy. We observed that not all staff on surgical wards washed their hands before and after each episode of direct patient care. For example, we observed that nurses on ward 7A (north) did not perform any hand hygiene following multiple patient care tasks. We also observed on ward 7B that out of a possible seven moments of hand hygiene nurses only completed hand hygiene following three of them. A student nurse on Swift ward did not perform any hand hygiene before or after taking patient’s clinical observations, for example, blood pressure, and pulse.
Hand hygiene audits were carried out in each surgical ward area by ward staff; this showed that
during the month of February they had all achieved high compliance rates.

We observed that phlebotomists on the surgical wards did not always wear gloves when taking
blood. Ward staff wore gloves when performing some clinical tasks, such as removing intravenous
lines, toileting patients and disposing of bodily fluids however, they did not routinely wash their
hands after removing the gloves. Washing hands after wearing gloves reduces cross infection
between patients.

Dirty fans were seen throughout the service including on Swift ward and in the patients’ pantry on
W5A, the clean utility room in 5A and in the dirty utility room on ward 11B.

Kitchen ward areas were mostly clean and free from clutter, however the ward 5 pantry area did
not have daily cleaning records and had out of date food items, for example, out of date desserts,
for patients’ consumption and one that was undated. Designated patient milk was delivered to
ward 5, which was out of date on arrival this was placed in fridge by housekeeping staff.
Additionally, patients’ food (squash, soup, biscuits) was stored in a room with clinical
consumables, including suction equipment, gloves, and tissues.

We observed most staff groups complying with the arms ‘bare below the elbow’ policy. This is an
infection prevention and control plan to prevent the transfer of infection from clothing that could be
contaminated, and allows clinical staff to wash their hands thoroughly. During our inspection, it
was noticed that a visiting surgeon within the theatre department wore a wristwatch and during a
consultant ward round several doctors were observed wearing long sleeves and watches.

We found that there were adequate hand wash facilities and hand cleaning gels throughout the
surgical wards and operating theatre departments. Hand gel was also available on patient bedside
lockers. During our visit we found an empty hand gel dispenser on ward 7A (north), we informed
the ward manager who immediately responded and assured us that the hand gel dispenser would
be refilled. We returned to ward 7A (north) during our inspection and found the dispenser to have
had been refilled.

Personal protective equipment, such as gloves and aprons were available in sufficient quantities
on all wards. Most staff used PPE appropriately when performing tasks where there was a risk of
contamination. However, we did observe staff on ward 5A and 5B not wearing aprons when
cleaning commodes, carrying urine bottles and cleaning bodily fluid from the floor.

Theatre attire was not always used appropriately. We observed staff wearing theatre caps and
masks outside of the operating theatre department. We saw that staff did not wear any protective
cover-ups over theatre clothes when exiting the department. This was not in line with the
Standards and Recommendations for Safe Perioperative Practice 2011 by the Association for
Perioperative Practice (AfPP). We asked the theatre matron and theatre operations manager if this
was standard practice, both were unaware that this occurred and assured us that this would be
addressed.

There were procedures in place to reduce the risk and monitor for signs of surgical site infections,
(SSI) in line with National Institute for Health and Care Excellence (NICE) CG 74 Surgical site
infections: prevention and treatment SSI rates. Surveillance was carried out in three categories of
surgery: total knee replacements, total hip replacements, and repair of fractured neck of femur.
SSI rates for July to September 2017 within the Trust

<table>
<thead>
<tr>
<th>Category</th>
<th>July-Sept 2017</th>
<th>Last 4 quarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Knee Replacement</td>
<td>1.3%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total Hip Replacement</td>
<td>0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Repair Fractured Neck of Femur</td>
<td>0%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

(Source: additional evidence request- DR 311)

Patients were screened for MRSA on admission to hospital in accordance with trust policy. All patients undergoing elective orthopaedic procedures were required to have a negative screen undertaken within the previous 28 days. However, operating theatre staff informed us that there were instances when patients had to be cancelled due to MRSA results not being available. These cancellations were not reported as incidences, this meant that the trust did not have oversight on how many patients were being cancelled. The trust had a service level agreement with a neighbouring health facility to undertake the reporting of MRSA blood samples.

There had been three cases of hospital acquired *Clostridium difficile* within the trust from September 2017 to March 2018.

The service had side rooms available to isolate patients suspected of having an infection. Specific care plans were also used for these patients. This enabled staff to take extra precautions and help prevent the spread of infection. In addition, where possible these patients were ‘cohort,’ that is kept in the same area where possible, to minimise the number of people that encountered them.

Patients who required a urinary catheter or peripheral venous cannula (a thin tube inserted into a vein to deliver medication) had supporting documentation completed to promote best practice and care and to reduce the risk of infections.

Minor local plastic surgery was performed in the procedure room located on ward 11B. During our inspection, we noticed contaminated surgical instrumentation placed on the ward reception area in clear plastic bags. We informed staff allocated to the area and the ward sister that this did not follow infection prevention guidance.

We found there were processes in place for clinical waste management. The service had laminated signs explaining which waste bag to use for specific clinical waste.

Sharps bins were readily accessible with lids temporarily closed for safety, however on wards 5A and 11B we saw that the sharps bins were used for non-clinical usage such as facemasks and tissues. The nurse in charge was informed, who correctly replaced the sharps bin.

Patient led assessments of care environment (PLACE) were completed on wards 7B, 8B, and the surgical assessment unit. They scored 100%, 100%, and 97.7% respectively for cleanliness.

All operating theatres within the trust had a six monthly cleaning schedule including air sampling as recommended by the Health and Social Care Act 2008 and the code of practice for the NHS for the prevention and control of healthcare associated infections in hospitals.
Environment and equipment

Although systems were in place to ensure equipment was looked after not all equipment was checked regularly. Emergency calls bells where not available in all wards.

However, the service had suitable premises in most areas although some areas required refurbishment.

The environment on the wards was visibly clean; an outsourced company provided the cleaning. Some ward areas required refurbishment; however, staff we spoke with were unaware of any plans to improve patient and staff areas.

In the ward kitchens, fridges, where food was stored were not checked daily and we found that the temperature range in some fridges was not within safe limits for the storage of food. A fridge temperature of 8 degrees Celsius (°C) or below is effective in controlling the multiplication of most bacteria in perishable food. It is recommended practice to operate refrigerators and chillers at 5°C or below. On ward 5, we noticed that the temperature range, on the days that the fridge had been checked, was never lower than 5.1°C and ranged from 7°C and 9.5°C on most days. At the time of our inspection, it was 8.8°C.

Ward areas on 7B, 8B, and 11B all had allocated storage cupboards in the main corridors. The doors were kept open. Items stored included needles, syringes, and bottles used for blood tests. The cupboards had no locks on the doors; this meant that clinical equipment was accessible to anyone who had been in the corridor.

There was no temperature monitoring in the storage cupboards. Exposure to high temperatures and increased humidity can alter the efficacy of equipment therefore daily temperatures should be monitored in line with best practice guidelines. WHO guidelines for the storage of essential medicines and other health commodities 2003 suggests that storage should be kept in a dry, clean, well ventilated area at room temperatures between 15° to 25°C.

Nurses were responsible for cleaning equipment used for patients. Stickers were used in some ward areas to show the equipment was clean and ready for use. Stickers on equipment in the surgical wards indicated cleaning had been done in the previous 24 hours.

Equipment was stored safely. Products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff. However, on wards 7B, 8B, and 11B a strong bleach based cleaning solution was kept unlocked in the ward dirty utility rooms.

During our inspection, we did not see any bariatric equipment in the ward areas. For example, there were no large size commodes for patients. However, staff told us some bariatric equipment was available to borrow from other wards, or the equipment store when required.

Access to the operating theatres and ward 7A (north) was controlled with an intercom device however; other wards areas such as 7B, 8A, and 11B did not have controlled access. This meant there was a risk of unauthorised access to those areas and of confused patients being able to leave the ward unsupervised.

Emergency call bells were not available in patients’ bays on wards 5A, 5B, 7B, 8B and 11B staff said if they needed help, they would shout. An emergency call button is usually found behind the patient’s beds for staff to alert other nursing practitioners that help is required quickly, for example if a patient collapses. Emergency call bells were available in the patients’ bathrooms and recently updated ward areas such as 7A and Swift ward.
Piped oxygen and suction was available behind each patient’s bed space. However, on the surgical assessment unit we saw that there was no piping attached to the suction unit and there was no oxygen mask readily available by the piped oxygen, which meant it would not be ready to use in an emergency. In addition, regular checks of piped gases and associated equipment were not undertaken.

The wards had equipment available to provide safe care and treatment. This included a hypoglycaemia (low blood sugar) box. On ward 5A, 7B pre-assessment unit and the surgical assessment unit, we found that checks had not been completed regularly and that sugar tablets and orange juice that had expired were in the box.

Most equipment was found to have been electrically tested and had yearly expiry dates that were visible and clearly written. In the preoperative assessment area and on ward 5A we found out of date electrical equipment and some other equipment that did not have an electrical sticker stating if a check had been completed.

Resuscitation equipment was available for use in an emergency and had been checked according to trust policy. However, on some wards within the surgical service some daily checks were missed.

Resuscitation missed checks

<table>
<thead>
<tr>
<th>Ward</th>
<th>Dates</th>
</tr>
</thead>
</table>
| 5A   | • 11;18;19;21 January  
• 21 February  
• 2; 3 March |
| 5B   | • No record for January available  
• 12;14;24 February  
• 6; 8; 9 March |
| 7B   | • 3;10; 15; 19 March |
| Swift| • Dates throughout all of September and October 2017 and  
• 20 January 2018. |

Oxygen cylinders on the resuscitation trolleys were stored in the switched off position. Some cylinders had keys to switch on the cylinders but these were not present on all the trolleys. This does not comply with a patient safety alert dated 9 January 2018, regarding the failure to obtain oxygen and continued flow from oxygen cylinders.

Resuscitation trolleys were locked with a breakable seal, which demonstrated the trolley had not been opened. We saw that on ward 7A (north), the resuscitation trolley had been checked but the tamper seal had not been attached. This meant the trolley could have been opened and the contents removed or tampered with.
The main operating theatres, treatment centre operating theatres and day surgery operating theatres were compliant with Health Technical Memorandum (HTM) 03-01, specialist ventilation for healthcare premises. This meant there were an adequate number of air changes in theatres per hour, which reduced the risk of infection to patients. However, the procedure room within ward 11B where local anaesthetic operations were performed did not have any air changes. The HTM on hospital ventilation states that there should be 15 air changes per hour.

The procedure room based on ward 11B did not have any emergency equipment within this area and relied on the ward resuscitation trolley, which was situated some distance away on the ward corridor. There was no indication in the room where the resuscitation equipment was situated; this meant that there could be a delay in a medical emergency.

There was a difficult airway trolley in the main operating theatres and the treatment centre operating theatres. This equipment was checked regularly which meant it was safe to use in an emergency.

Consumable items, for example syringes, needles, and fluid giving sets were mostly within their expiry dates and equipment was serviced internally with a record of equipment maintenance kept centrally within the hospital.

The hospital had a sterile services unit onsite for decontamination and sterilisation of surgical instruments. Washer disinfectors and sterilising equipment within the sterile services unit had reached their life expectancy and were starting to fail; this had been placed on the hospital risk register. Operating theatre staff from both the main operating theatres and treatment centre operating theatres told us that instrumentation turnaround times were poor and occasionally patients had to be cancelled due to equipment failure. These failures were not reported as an incident on every occasion, but this risk was on the hospital risk register.

**Assessing and responding to patient risk**

There were systems in place to recognise and respond to deteriorating patients’ needs, however these were not always complied with. Venous thromboembolism was not reassessed 24 hours after admission, emergency box for treating patients with hypoglycaemia contained expired items, and audits of the use of the theatre checklist were of the documents rather than observational audits of practice.

Risk based pre-operative assessments were carried out in line with national guidance. Patients for elective surgery attended a nurse led pre-operative assessment clinic prior to their operation. During the assessment all required tests were undertaken, for example, MRSA screening and blood tests. This was in line with NICE guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016) and guidance from the Modernisation Agency.

Patients that were identified as being a higher risk or had complications diagnosed following their test results were referred for further review with a consultant.

Risk assessments were also carried out on patients when they were admitted to the surgery service. This included risk assessments for falls, malnutrition, and pressure ulcers. These were documented in the patient’s records and included actions to mitigate any identified risks. These assessments should be updated regularly however; we saw that this did not always happen.
Clinical harm reviews had not been completed due to the failure in the patient data system. A clinical harm review allows medical staff to assess the level of possible harm caused from a delay in a patient treatment and act accordingly, for example by prioritising their treatment. There was no evidence that the duty of candour requirements had been met. 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. Patients had not received any communication regarding the long wait for treatment and what to do if their condition deteriorated. Following our inspection, we were told that the trust had developed a stabilisation and transformation plan, which included the weekly tracking of patients. This meant that patients who required further investigations were contacted and informed of any delays.

During our inspection, we observed a morning handover; staff received a full report of the patient’s condition and actions of care for the day. On ward 8A, we saw the staff greeting each patient by name and discussing their care with them.

Safety huddles were also completed, following the morning handover. The safety huddles are a process designed to help reduce patient harm. The huddle might include topics such as falls, risk, pressure ulcers, deteriorating patients, and patients’ nutritional needs. Staff on the wards explained that these had recently been implemented, but they thought it was a good idea and helped them all understand the patients’ needs better.

Intentional rounding was used to look for emerging risks and concerns. Intentional rounding involves a regular review of patients to ensure changes are noticed early and acted on before an incident can occur. We saw records of intentional rounding being carried out in the patient records we reviewed.

The National Early Warning System (NEWS) is used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: ‘acutely ill adults in hospital: recognising and responding to deterioration’ (2007). The trust used a hand-held data system to input patient observations, such as blood pressure, pulse, oxygen levels, and temperature. The system was programmed to evaluate the recordings and alert staff if the patient required medical assistance. Staff we spoke with said the system worked well and outreach care nurses responded appropriately, when requested, to see patients where NEWS scores had increased.

The World Health Organization (WHO) safer surgery checklist was seen to be used in operating theatres within the main hospital and the treatment centre. The checklist is used to improve safety during surgery by reducing mistakes, deaths, and complications. The five steps to safer surgery include, checking the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. The theatre staff completed WHO audits to establish if the five steps to safer surgery were being completed in line with the recommendations, however these audits were not observational audits and only looked at the completion of the checklist. Therefore, we were not assured that WHO audits were carried out effectively. The audits were completed using a tick box checklist in to establish that consistency and clarity of the WHO checklist were being completed. Two never events had occurred in the previous 18 months which both involved operating on the wrong finger. To prevent further such incidents, certain stages of the checks were emphasised. For example, any digit to be operated on was required to have marking around its circumference pre-operatively. There had been a separate never event regarding a disposable
item being retained during surgery. To prevent similar occurrences any disposable items were accounted for as part of the swab, needle, instrument checks.

Within the operating theatres National Safety Standards for Invasive Procedures (NatSSIPs) could be found in the departmental policies, which were kept on the trust website, however not all operating theatre staff fully understood what these were. NatSSIPs provide standards set out to deliver safe care for patients who have operations. This allows hospitals a process to deliver standardised care.

The staff who worked in the minor treatment room on ward 11B used a modified WHO checklist. All procedures undertaken within the treatment room were under local anaesthetic. All staff working within the area were clinical support workers (CSWs) who had received basic life support training. However, no formal theatre training, for example scrub skills, had been completed. The minor treatment room did not contain any emergency equipment, but it was available on the ward, nearby. When performing local anaesthetics it is standard practice that a lipid emulsion fluid should be readily available to treat local anaesthetic toxicity, when a patient has a reaction to the local anaesthetic. Lipid emulsion fluids are used to stop a reaction by blocking the local anaesthetic. These lipids were not readily available should a patient have a reaction. Operating theatres within the main hospital block, including day surgery and the treatment centre, had lipid emulsion fluid on the resuscitation trolley.

Following minor operative procedures, patients were left to sit in an area in the main ward corridor area without any nursing supervision or regular checks. Staff we spoke with said this was standard procedure and if patients felt unwell, they alerted a member of staff who would take them into a dressing clinic area until they felt better.

Risk assessments for venous thromboembolism (VTE) had not been carried out in line within NICE clinical guideline: venous thromboembolism: reducing the risk for patients in hospital 2015. This guideline requires patients to have a VTE assessment on admission to hospital and 24 hours later. During this inspection, we saw that VTE risk assessments had been carried out on most patients on admission; however, this had not been carried out on any patient 24 hours later.

We reviewed 20 patients’ prescription charts, 16 charts had been completed on arrival for a VTE assessment, but only four charts had been fully competed 24 hours after admission. Staff were aware that a VTE assessment had to be completed on arrival however, they were not aware that another assessment should be completed 24 hours later. The trust’s prescription chart states that a reassessment after 24 hours is required.

Trust audit results for VTE completion showed 97% compliance within the surgical services from April 2017 to July 2017. However, VTE compliance was not reported on electronically as the data was not accessible on the new patient information system. This had been added to the trust risk register.

Staff told us they were aware there was a trust sepsis policy and that ‘sepsis six’ boxes were available on the wards. However, staff could not assure us that they had received sepsis six training. Sepsis is serious complication of an infection. ‘Sepsis six’ is a system whereby six steps to managing patients suspected of having severe sepsis, neutropenic sepsis, or septic shock.

Patients with known allergies wore a coloured wristband, which acted as an alert to staff.

Staff had blood transfusion training every two years in line with the trust policy. Staff trained in blood transfusion were aware of the risks to patients when receiving blood. However, during our
inspection there had been a never event regarding the wrong blood being given to a patient. The incident had been investigated and actions to reduce the risks of a similar incidents happening again were being implemented.

There was a major haemorrhage process within the trust. Staff from ward11B and all operating theatres in the trust could explain how to use this policy in an emergency.

Nurse staffing

Most areas did not have enough nursing staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing levels and skill mix were planned and reviewed daily using a safe staffing acuity tool. The ward nurse in charge compared staffing numbers and skill mix to the patients' acuity and dependency. This process is in line with the National Institute for Health and Care Excellence (NICE) in relation to its guidelines for Safe Staffing (SG1).

Staffing levels were reviewed three times a day by the duty surgical matron, and a twice weekly 'look ahead' was completed to ensure staffing risks were addressed and actioned in advance. Each ward was rated red, amber, green, according to their staffing levels, for early, late, and night shifts.

During our inspection, we also observed the duty matron assessing wards within the surgical service, using a ‘red flag’ system. This allowed senior staff to recognise the need for extra help on specific wards and allocate staff accordingly.

The trust had a just commenced ‘re-set Tuesday’ initiative. This was introduced to reduce the amount of staff being moved from their allocated wards every Tuesday, which had been planned to improve the continuity of patient care and staff morale. However, during our inspection, part of which took place on a Tuesday, matrons were advised to move staff as red flags had been triggered, indicating low staffing levels, on certain wards.

Within the trust an enhanced nursing care team had been developed. The team consisted of senior care support workers that had received specific training in order to care for patients that required particular care. These patients included those living with dementia and those with raised national early warning scores.

The trust had regular recruitment events and recruited nurses from overseas. The surgical directorate was actively engaged with this process and we saw that vacancies had decreased and were regularly reviewed. The senior surgical staff were engaged with this process and were confident that vacancies would be filled. There were induction programmes for new or temporary staff working within the surgical wards. This included where to find emergency equipment, knowledge of the hospital bleep system and standard procedures used within the trust.

Most wards during our inspection reported a high number of nursing staff vacancies. For example, ward 5B had ten band 5 vacancies and five band 2 vacancies; the pre-op assessment unit had five band 5 and seven CSW vacancies; Swift had four band 5 vacancies. The operating theatres had a vacancy rate of eight whole time equivalents (WTE).
The trust had recently employed trainee-nursing assistants. The nursing assistant role is a new support role introduced to the health care workforce. The nursing assistants work alongside other care professionals on the ward areas. Their two-year course is university based, supplemented with practical work in the hospital setting. After completion of the two-year course, it was planned that qualified nursing assistants would be registered with the Nursing and Midwifery Council. This will allow nursing assistants to perform some of the roles of a qualified registered nurse, for example, performing dressings, and completing medicine rounds.

Wards 5A, 5B, 7B, 8B, and 11B, all employed trainee-nursing assistants. However, the trainee nursing assistants had replaced a WTE qualified nurse within the ward staffing levels. Staff we spoke with explained that this had caused them some concern over the quality of care being given to the patients and had reduced the qualified nurse to patient ratio.

Nurses of all grades in Surgical Assessment Unit (SAU) told us they believed there was a lack of understanding of the staffing needs and variable workload within the department and that sometimes bleep holders (who managed staff shortages) were ward focussed only. We were told that nurses were often moved out of SAU to help ward nurses, when SAU were already short of staff.

The operating theatre departments within the trust used the Association for Perioperative practice (AfPP) staffing policy template. Managers within the operating theatres told us they used an overtime system and bank staff to ensure staffing levels were within recommended guidelines. Theatre staff told us that they were sometimes reallocated to work on ward areas during busy periods within the hospital. Theatre staff told us that they had not been trained to complete certain ward duties they had been asked to perform. This had been raised to operating theatre managers who ensured all staff were aware of procedures they could perform within their role. In addition, operating staff told us that when they had been on night duty to be available for any emergencies, they were asked to work on the wards and leave the operating theatre unattended.

The minor procedure operating theatre based on ward 11 B was staffed with clinical support workers. AfPP - guidelines staffing for patients in the perioperative setting 2014, states that staffing levels should reflect the needs of the patients and that a ratio of qualified and non-qualified staff should be followed. The recommendations include as a minimum two qualified scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner, and one recovery practitioner per patient.

The trust has reported their staffing numbers below for year of 2016/17 and year to date which covers April to October 2017.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th></th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Surgery</td>
<td>staff</td>
<td>staff</td>
<td></td>
</tr>
</tbody>
</table>

The fill rate for nursing staff in 2017/18 year to date was notably less compared to 2016/17. However, the actual number of staff has remained similar whereas the number of planned staff increased from 388 to 457.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Vacancy rates
From December 2016 to October 2017, the trust reported a vacancy rate of 11.3% in surgery for nursing staff. This was above the trust’s target of 6%.

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

Turnover rates
From December 2016 to October 2017, the trust reported a turnover rate of 18.4% in surgery for nursing staff. This was above the trust’s target of 12.7%.

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

All nurses leaving the service were given the opportunity of an exit interview with the matron. In addition, there was the opportunity to complete an exit interview anonymously, on line. This helped identify any themes to understand why staff left. Some staff left due to promotion within the organisation or for promotion to another healthcare provider.

Sickness rates
From December 2016 to October 2017, the trust reported a sickness rate of 5.3% in surgery. This was above the trust’s target of 3.3%. We spoke with senior nurses and medical directors who told us that due to pressures over the winter period, staff morale was low and subsequently had led to an increase in sickness levels.

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

Staff who had a period of sickness absence had a return to work welfare interview immediately upon their return. The purpose of the interview was to ensure the staff member was fit to be back at work, and to ensure any reasonable assistance required was identified. The service monitored their sickness and absence and had policies in place to ensure that absence monitoring was carried out correctly.

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 data the trust has provided does not include details on the number of shifts filled by substantive staff in total shift figures, which means we cannot provide an accurate bank and agency usage figure.

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

Staff told us they generally used the same agency nurses on each ward whenever possible. This ensured continuity of care for patients and ensured agency staff were in a familiar environment, with staff they knew. During our inspection on ward 8B, we saw a good relationship between the permanent staff and their agency workers.

There had been no agency usage within the operating departments within the trust from October 2017 to March 2018.
Medical staffing

The service almost always had enough medical staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.

The trust has reported their staffing numbers below for year of 2016/17 and year to date which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Surgery</td>
<td>262</td>
<td>296</td>
</tr>
</tbody>
</table>

The fill rate for medical staff in 2017/18 year to date has increased slightly since 2016/17.

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

Vacancy rates
From December 2016 to October 2017, the trust reported a vacancy rate of 10.0% in surgery for medical staff. This was above the trust’s target of 6%.

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

Turnover rates
From December 2016 to October 2017, the trust reported a turnover rate of 10.4% in surgery for medical staff. This was lower than the trust’s target of 12.7%.

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

Sickness rates
From December 2016 to October 2017, the trust reported a sickness rate of 1.4% in surgery. This was lower than the trust’s target of 3.3%.

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

Bank and locum staff usage
This information was requested within the universal provider information request spreadsheets, to be completed within a standard template. The data the trust had provided did not include details on the number of shifts filled by substantive staff in total shift figures, which meant we were unable to establish an accurate bank and locum usage figure.

The trust reported three of the five areas with highest bank and agency staff use to be in surgery. These are: ophthalmology, anaesthetics and theatres, and surgical specialties (plastics). It attributes this to a high vacancy rate but reports that most positions have now been filled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)
Staffing skill mix
In October 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 higher than the average for England.

Staffing skill mix for the whole time equivalent staff working at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>11%</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

Records of patients’ care and treatment were not always completed appropriately. We found that some records were not always stored securely and that patient confidentiality was not always maintained.

Wards within the surgical service did not always keep confidential information secure. On our previous inspection in October 2015, we noted that not all patient records were stored securely in the ward areas. Medical records should be stored in locked cupboards to ensure that unauthorised individuals cannot access confidential information. Medical records were not locked on wards 7A (north) and 7B; this had been an outstanding issue from the previous inspection. On ward, 11B patients’ medical notes were stored in cupboards behind the ward reception area. We noticed on two occasions that these cupboards were open when the reception area was unmanned.

Patients and visitors could access medical and nursing records, which were kept within the patients’ bays on some wards. This information included name, address, telephone number, date of birth, hospital number, next of kin details and reasons for admission, including operation notes and all medical reviews which had been carried out during the admission.

Although records we reviewed were, legible, timed, and dated some were not fully completed. We looked at 28 sets of records and saw that the doctor looking after the patient had documented daily reviews. They were clear and the care pathway plan was documented. There was evidence
of multidisciplinary participation, with clear assessments by the physiotherapists, occupational therapists, and dieticians where appropriate. However, not all nursing records were fully completed. For example, fluid balance charts were not completed fully and the fluid balances were not totalled up.

Patient risk assessments such as falls, pressure areas, and malnutrition universal screening tool (MUST) were completed on arrival to the ward. ‘MUST’ is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. However, these risk assessments were not regularly reviewed during the patients’ hospitalisation.

**Medicines**

Medicines were prescribed appropriately however they were not consistently stored or administered correctly. Fridge temperatures were not always monitored and when out of range were not reported. Some medication was out of date. Some medication was not given when prescribed.

Medicines were not stored securely in clinical areas. Within the medicines trolley on ward 5A and ward 5B, loose tablet strips were stored in plastic cups. This is not recommended practice as it increases the risk of medication errors. We saw that patient’s own tablets were being stored within the medicines trolley and were being given to other patients, as the ward did not have enough stock. We highlighted this to the ward staff who said they were unaware of the correct procedure. However, medicines were kept in locked cupboards with only appropriate staff having access to keys or coded door numbers. The nurse in charge kept the controlled drugs cupboard key.

During our inspection, not all staff followed the safe administering of medicines in accordance with guidance from the Nursing and Midwifery Council. We found trust policy was not consistently followed on Swift ward and SAU. For example, the CD check book on Swift ward showed that CD’s had been removed from the CD cupboard without a second nurse’s signature and IV therapy was observed to be given on Swift ward and SAU with only one nurse checking the patient’s identification. Nursing staff we spoke with confirmed that their medicines policy required two nurses to check the patient’s identification prior to administration of IV therapy. However, they also told us there was insufficient time and staff available to do this, and it was normal practice for one nurse to administer the drugs at the bedside.

We observed nursing correctly identified the right patient prior to administering medications. The patient was asked if they had any known allergies, this is in line with maintaining and sharing drug allergy information as recognised by National Institute for Health and Care Excellence (NICE) clinical guideline 183 (2014).

Staff did not always monitor and record temperatures of fridges used to store medicines, to ensure that medicines stored within the fridges were kept within their required temperature range. We reviewed the fridge temperature checks, which showed that fridge temperatures had not been checked daily.

Out of range fridge temperatures were not reported. Staff we spoke to were unsure of the process necessary to report this. The trust had a quick guide reference of how to report and monitor refrigerated medication correctly. This information was available on the trust intranet Knowledge Centre.
We found inconsistencies with the monitoring and recording of ambient room temperatures. We reviewed the ambient temperature records of the intravenous (IV) medication storage room on swift ward and found eight consecutive days when the room exceeded its maximum temperature range in March 2018. In addition, we found that the surgical assessment unit (SAU) did not record the ambient room temperatures of either the IV storage room or the clean clinical room.

In the medicines cupboard we saw out of date medicines, such as anti-sickness tablets, anti-allergy tablets, and eye drops. Ward 5B had some out of date acetone dated March 2017, stored within the controlled drug cupboard awaiting a pharmacist to remove it.

The ordering, receipt, storage, administration, and disposal of controlled drugs were carried out in accordance with the Misuse of Drugs Regulations 2001. However, on several wards within the surgical areas, we found out of date controlled drugs awaiting collection from the pharmacy. For example, on Ward 11B, staff had recorded that out of date controlled drugs had been in the cupboard for 17 days following their expiry date and were awaiting collection.

During our inspection, we noticed that controlled drugs checks were not completed daily according to local trust and national guidance. In addition, we saw that controlled drug records were not kept in accordance with recommended guidance on the record keeping of drugs. For example, we saw that entries had been crossed out.

Medicines were mostly administered as prescribed on the prescription chart. However, we saw that some medicines had been missed and not administered later. We found that doses of time critical medicines had not been given to some patients. This included on ward 5a, antipsychotic medications, diabetic medication, neuropathic pain analgesia, and anti-hypertensives. The medications were recorded as not given on the patients’ prescription charts due to the medications being out of stock. Also on ward 5B, we saw that a patient had missed doses of an anti-blood clotting drug that had not been given from the 12 to 15 March 2018. This incident was raised during the inspection and staff reassured us that this would be acted upon.

Reported medication errors were mainly due to delays in delayed receipt of inpatient medication and administration errors. The most common medicines involved included diabetic medication, cancer treatment, and antibiotics.

- 29 incidents were reported between April 2017 and May 2017
- one incident was recorded as severe harm, six were moderate harm and 22 were minor incidents.
- one high, one moderate, eight low, 12 very low incidents, and seven that did not have a rating grade.

(Source: Routine Provider Information Return (RPIR) doc P82.92: medication forum minutes)

The trust ensured that there was medicines information on the intranet Knowledge Centre.

Medicine cupboards within the operating theatres were left unlocked, whilst theatres were in use to allow easy access to medicines. However, the main operating theatre pharmacy cupboard within the main theatre department was broken, which had had been reported on the 12 March 2018. Its repair was outstanding at the time of our inspection.

Anaesthetic medicines were drawn up and left unattended within the anaesthetic room. There is currently no specific advice as to the storage of anaesthetic drugs from the Royal College of
Anaesthetists. However, there is clear guidance of the storage of controlled drugs and during our inspection, we saw a syringe labelled with a controlled drug label on the work surface, unattended in the anaesthetic room. We informed the appropriate personnel immediately who informed us that there was no controlled drug in the syringe only saline. The National Patient Safety Agency (NPSA) advice on labelling injectable medicines recommends that there is clear identification of the contents of any syringe that is for patient administration, which includes syringes of anaesthetic medicines.

Incidents

Patient safety incidents were not always managed well and learning from them was variable. Staff recognised reportable incidents however, did not always report them in a timely manner. For example, following a never event staff did not complete an incident report until 20 days after the event.

Staff we spoke with understood their responsibilities regarding reporting incidents. The trust used an electronic reporting system on which all staff had been trained to use. However not all staff completed incident reporting in a timely manner. For example, following a never event staff did not complete an incident report until 20 days after the event.

On most wards, we saw reported incidents were put on display to raise awareness. Staff were not always able to tell us about any changes in practice, as a result of incidents being reported.

Nursing staff on the wards told us managers shared learning from incidents at daily staff huddles. However, feedback on incidents were delayed pending outcomes and opportunities of learning were missed.

During our inspection, we asked senior staff how information was passed to the surgical wards regarding never events and incidents. We were told that information regarding these events was cascaded to staff by word of mouth, there was limited written evidence passed to members of staff. We were told that incidents were discussed at team meetings. We reviewed minutes from a team meeting on ward 8B which showed that incidents and actions had been discussed. The surgical teams had worked hard to make positive changes to the reporting culture and to improve learning from incidents.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when an incident had occurred. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed, and offer support. We saw evidence that duty of candour had been applied appropriately following recent never events within the surgery division.

A ‘patient safety matters’ newsletter had been introduced by the trust, on patient safety and the reporting of the incidents. We reviewed one newsletter dated March 2018; it contained information for staff regarding reported incidents and focused on two recent serious incidents.
Specific incident reports were completed within a 72-hour period following all serious incidents and any incidents that required further investigation. The report included a summary of events during the patient’s hospitalisation, concerns as to why the incident happened, immediate action taken, staff support, learning, and details of whether duty of candour had needed to be applied. A serious incident panel had been commenced during our inspection, which met twice weekly and considered and tracked progress of all serious incidents. All were allocated an executive sponsor and a lead investigating manager who liaised with the patient or their family and ensured the incident was investigated promptly and thoroughly and that any immediate lessons could be learned.

**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 January 2017 to March 2018, the trust reported three incidents classified as never events for surgery at Lister hospital. One of these events took place in November the previous year.

- **Surgical invasive procedure – Retained gallbladder bag (November 2016)**
- **Surgical invasive procedure – K-wire put on the wrong finger (July 2017)**
- **Wrong blood products given to the wrong patient (March 2018)**

Following our inspection, we were informed that three further never events had taken place within the surgical division:

- A retained guide wire after insertion of a central venous catheter. This incident had not been reported as an incident until 20 days after the event.
- A patient who required oxygen therapy had their tubing connected to a port supplying air rather than oxygen. Despite the patient’s oxygen levels continually decreasing and routine
bedside safety checks being carried out during this period, this error was not identified for 10 hours.  
- A naso gastric tube incorrectly placed.

There had been investigations carried out and lessons learned by the surgery teams following never events. For example, following the wrong site surgery appropriate action had been taken which included a standard operating procedure regarding the marking of surgical sites. We also observed that the checking of theatre equipment such as swabs, needles, and surgical instrumentation included items that may be used within a patient’s body.

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported ten serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England from January 2017 to December 2017.

These were:
- Surgical/invasive procedure incident meeting SI criteria with four (40% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (20% of total incidents)
- Slips/trips/falls meeting SI criteria with two (20% of total incidents)
- Confidential information leak/information governance breach meeting SI criteria with one (10% of total incidents)
- Abuse/alleged abuse of adult patient by staff with one (10% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The graph bellow shows a summary of serious incidents reported over the last 12 months.
Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients, and visitors.

The NHS Safety Thermometer audit provides a ‘temperature check’ on levels of harm and enables the measurement of ‘harm free care’. Harm free care is defined by the absence of pressure ulcers, harm from a fall in hospital, urine infection (in patients with a catheter) and new VTE.

The NHS Safety Thermometer information was collected and displayed for staff, patients, and visitors to see. There were also many poster information displays demonstrating best practice regarding pressure ulcer and falls prevention.

The ward sisters explained the actions they took to minimise the risk of avoidable harms. They monitored the use of and completion of risk assessments and fluid charts; it had been identified by the trust that these were not always completed. Where the ward sisters found issues relating to care, they raised them with staff directly. They also used the morning and evening safety brief to reinforce messages relating to patients’ safety.

The trust had launched the “end pyjama paralysis” a national campaign, to encourage patients to get dressed and out of bed to encourage mobility which in turn reduced the possibility of pressure ulcers.

Safety Thermometer report – Surgical division

The graph below shows the data for East and North Hertfordshire NHS Trust as a whole.

(Source Additional evidence request – DR 145 Safety Thermometer report – March 2018)

The graph below shows the data for East and North Hertfordshire NHS Trust as a whole.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at East and North Hertfordshire NHS Trust

(Source: NHS Digital)

Major incidents

The service planned for emergencies and but not all staff understood their roles if one should happen.

Not all staff we spoke with in theatres and on surgical wards knew what action to take in the event of a major incident. However, staff knew where to find major incident plans on the trust’s intranet.

Staff we spoke with could not tell us if they had training in responding to major incidents.

We asked staff how they would respond to a fire. Staff explained the alarm bell system and where patients would be moved in the event of a fire. Patient fire slide sheets were available on each level however, these were kept locked in a metal box. The matron on call and bed managers were able to unlock the box, staff we spoke with were unaware of this process.
Is the service effective?

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence of its effectiveness. Managers did not always check to make sure staff followed guidance including guidance on sepsis. Some audits were not completed and results were not always followed up. For example, WHO audits were only carried out retrospectively.

Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations. Local policies, such as the infection control policy were written in line with national guidelines. Policies were available on the trust intranet and clinical staff we spoke with knew how to access them. However, some nurses said that the intranet contained too much information and it was difficult to find things they needed, especially when busy. For example, contact details for the safeguarding team or guidance on the management of patients with loose stools.

The pre-operative assessment clinic assessed patients in accordance with NICE NG45 ‘Routine pre-operative tests for elective surgery’ (2016). For example, MRSA screening and blood tests were undertaken following this guidance.

The trust had a NICE guidance policy and there was a designated lead for each surgical speciality who was responsible for providing regular assessments of new guidance. Levels of compliance with national guidance were reported to the clinical audit and effectiveness committee. Where new guidance was not met, the designated lead carried out a gap analysis and a risk assessment. New guidance was shared at the ‘rolling half day’ monthly clinical governance meeting.

There was participation in some relevant local and national audits, including clinical audits, for example, surgical site infections in line with NICE guidelines QS49 ‘Surgical Site Infections’ (2013). However, the service did not participate in all mandatory audits including the National Audit of Ophthalmology and the Robotic Colorectal Surgery audit. Other national mandatory audits had not been started, although completion was due by 31 March 2018. This included the Colonic Polyp Recovery audit and Sedation and Analgesia for Colonoscopy audit.

Surgery services used the American Society of Anaesthesiologists (ASA) grades as a guide regarding a patient’s fitness to undergo an anaesthetic. This was in line with NICE guidance. The ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have.

Staff told us it followed NICE NG51 Sepsis: recognition, diagnosis and early management guidance. Clinical areas had sepsis boxes which contained information for staff on how to recognise and manage sepsis. However, on most wards the boxes were stored in clinical rooms off the main ward and were not easily visible to staff. Nursing staff were aware of the sepsis box but confirmed that they had not received any extra training in sepsis. Audits on compliance to sepsis guidelines were not done in the surgical service and therefore we were not assured care was being provided in line with national guidance on sepsis.

The theatre department audited its use of the World Health Organisation (WHO) safer surgery checklist. However, this was not a qualitative audit and did not look at compliance to WHO.
guidance. The trust told us urology services had started a qualitative WHO audit in March 2018 which did look at compliance to guidance. Results varied from 67% to 89% compliance. This audit had been started recently and therefore we were not assured about the quality checks and governance surrounding compliance to WHO safer surgery.

Staff assessed most patients for venous thromboembolism (VTE) prior to surgery and were prescribed VTE prophylaxis in accordance with NICE guidelines QS3 statement 5: ‘Venous thromboembolism: reducing the risk for patients in hospital’ (2010). For example, the choice of mechanical VTE prophylaxis was based on patient clinical condition, the type of procedure being undertaken and patient preference. Patients who required anti-embolism stockings had their legs measured and patients were encouraged to wear the stockings until their mobility was no longer reduced. However, not all patients were assessed for VTE in line with NICE guidance.

The trust carried out an audit of compliance to use of antibiotics in line with antimicrobial guidelines in November 2017. Results for surgery services varied, with ward 11b, recording 33% compliance, 67% in SAU and 100% in ward 5a and 5b. We were told the audit results were fed back to the trust antimicrobial forum in March 2017, and that this forum included a surgical representative who fed back the results to the rest of the surgical division. A weekly antimicrobial stewardship ward round has since been commenced for surgical patients and this was in addition to an existing one for orthopaedic patients which was commenced in February 2018. We were told there was a plan to feedback results from these interventions to the surgical team at a future date.

The surgery service contributed to some national audits and benchmarked their performance against other healthcare organisations to ensure they were following best practice. This included the National Hip Fracture Database audit, the National Emergency Laparotomy Audit (NELA) and Patient Reported Outcome Measures (PROMS).

Patients over 60 years old who were admitted with a fractured neck of femur (hip fracture) were seen by an orthogeriatrician within 72hrs. This was in line with NICE CG124, ‘hip fracture management’ (2011). We were told compliance to this was audited monthly but we were not shown any evidence of this.

Medical staff followed professional guidance and recorded medical device implants using the National Joint Registry (NJR). The NJR collects information on joint replacement surgery and monitors the performance of joint implants. This ensured traceability at national level, if concerns were raised about the quality of joints or any adverse effects.

Staff assessed patients’ physical, mental health and social needs in a holistic manner. Medical staff obtained this information when patients were admitted. In addition, nursing staff recorded information about patients’ living accommodation to help discharge planning.

Staff used some ‘care bundles’ to ensure best practice was followed. Care bundles bring together a number of focused interventions, which improve care and treatment in a particular aspect of care, or treatment of disease. For example, there was a urinary catheter care bundle and an insertion and management of peripheral venous (PVC) access care bundle. Compliance to care bundles was audited. Results from the services’ most recent PVC audit indicated compliance ranged from 88% to 96%. This was lower that the trust target of 100%. Compliance to the catheter care bundle also ranged from 88% to 96%. However, for some aspects of care, compliance fell below this. For example, on wards 11B, 5A and 8B, compliance to daily review of continued need for a urinary catheter was 50%. Audit results were not displayed in the clinical area or staff rooms we looked in and most nursing staff we spoke with were unaware of what
compliance in their area was.

Junior doctors told us there was no system of sharing alerts issued from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA regulates medicines, medical devices, and blood components for transfusion in the UK.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. However fluid charts were not completed consistently.

Special feeding and hydration techniques were used when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patients waiting for surgery were kept ‘nil by mouth’ in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff followed guidance from the Royal College of Anaesthesia, Raising the standards (2012), and offered specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid before surgery. Elective patients were given clear instructions about fasting prior to admission and formulated drinks were provided to patients at their pre assessment appointment. Information was given verbally at the pre-operative assessment and in writing. For example, patients were told not to eat for six to eight hours before a general anaesthetic and were encouraged to drink clear fluids up to two hours prior to a surgical procedure.

Staff had access to snacks and drinks, which they could provide to patients between mealtimes. This helped to support patients’ nutritional intake and hydration.

Patient’s nutrition and hydration needs were assessed on admission and monitored, and recorded using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: ‘Physical and psychological needs’ (2012). During our inspection we observed MUST assessments were completed on 12 out of 14 sets of notes we looked at. Reassessments were regularly completed, although not always weekly as best practice guidelines state. Food diaries were inconsistently completed with some meals not recorded on most sheets we looked at. One diet sheet had question marks entered for every meal. The service audited its completion of food diaries and MUST reassessments which showed in February 2018 weekly MUST completion was 81% and food diary completion was 79%.

Staff used fluid balance charts to monitor patients’ fluid intake and output. Fluid balance charts were inconsistently completed and not totalled up every 24 hours. The service audited its completion of fluid balance charts on some wards, which showed in February 2018, recording of input was 80% and recording out output was 77% and 24 hour total was 82%. However, some wards reported much lower compliance; for example, ward 5B, compliance was 42%, 33% and 58% respectively. There were no actions recorded to improve future compliance. The service told us poor compliance was discussed at divisional board meetings and ward meetings. Some wards in the surgical division were not audited or did not submit data to the February audit. This included swift, ward 7A and ward 7B. We asked the service why some wards had not completed the fluid balance audit and we were told that only wards which provided a minimum of 20 audit results were included in the data.

Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against
vomiting and nausea). We observed a patient being given an antiemetic intravenously in the
recovery area as they had complained of nausea post operatively. This was managed effectively
before the patient was admitted back to the ward. In addition, the recovery nurse informed the
ward nurse who was looking after the patient postoperatively.

Patients had jugs of water within reach. These were regularly refilled. Spill cups were provided to
help patients drink independently. Intravenous fluids were prescribed when necessary.

Patients at risk of malnutrition were referred to a dietitian. Dietitians reviewed patients who had
been referred to them, made treatment plans and recommendations. We saw that full fat milk had
been obtained for specific patients to ensure their nutritional needs were met following advice
from the dietitian.

Staff accessed speech and language therapists for assessments of a patients swallowing ability.
We observed breakfast being served from a hostess trolley. There was a variety of food options,
including hot toast and cereals. Main meals were available which catered for specific dietary
requirements including vegetarian, halal, gluten free, diabetic and altered texture meals. Patients
chose their meals in advance. All of the patients we spoke with said they enjoyed their meals and
had sufficient food to meet their daily requirements.

Patient led assessments of the care environment scores (PLACE) showed scores for food on ward
11 were 95% satisfaction in June 2017. PLACE scores for food in the other surgical wards were
not available.

**Pain relief**

(The service mostly managed patients’ pain effectively and provided or offered pain relief
regularly.)

The surgical services had access to chronic and acute pain teams for advice and support with
patients in pain. However, there were insufficient patient controlled analgesic pumps (PCA) for all
patients who required a PCA to control their pain. This was on the service risk register.

Pain was assessed and recorded using the National Early Warning Score (NEWS) and we saw
these were completed on the electronic patient records. Staff regularly asked patients if they
were in any pain. Staff had access to an appropriate tool to help assess the level of pain in
patients who could not, or found it difficult to speak, such as happy and sad faces. Staff also said
they would observe patients’ facial expressions, body language and a change in behaviour.

Patients were provided with pain relief in a timely manner. Most patients we spoke with said they
were regularly asked if they were in any pain by nurses and clinical support workers. Pain relief
was discussed during handovers and concerns were referred to the consultant and a member of
the pain team. In the surgical assessment unit, we saw patients waiting in chairs who had asked
for pain relief and we saw that nurses responded to this quickly.

Staff chose appropriate pain relief using the ‘pain hierarchy’ (starting with common medicines and
moving to more powerful medicines some of which were controlled drugs). Commonly used
painkillers were prescribed routinely but if these were not effective, staff asked the pain team for
advice and for additional medicines to be prescribed to ensure patients were pain free and
comfortable.
Patient outcomes

The service monitored the effectiveness of care and treatment but did not always use the findings to improve them. Outcomes for patients were variable with the trust performing better than the national average for some indicators, for example risk of readmission after planned urology surgery, but worse for others. The risk of readmission following elective surgery was worse than the national average, and the risk of readmission following unplanned plastic surgery was much worse than the national average. Action plans to improve outcomes were not embedded across all specialities provided by the service.

The service took part in national audits, such as the elective surgery patient recorded outcomes (PROMs) programme. PROMs were reviewed by the clinical lead for the relevant speciality. External peer reviews were carried out to improve services and recommendations from reviews that had been implemented. For example, a review of urology services carried out in May 2017 identified several actions for service improvement. We saw an action plan last updated February 2018 which identified outstanding actions and revised delivery dates.

The hospital benchmarked patient outcomes with other trusts and presented findings to speciality teams. For example, the trust audited its ability to get patients with hip fractures to theatre within 36 hours, which is the national standard. Audit results showed most patients did receive surgery within 36 hours and that the trust’s results were above the national average by at least 10% from August 2017 to January 2018. In January 2018, 84% of hip fracture patients were operated on within 36 hours. This fell just below the national aspirational standard of 85%. We saw evidence that the outcome of this audit was shared with trauma surgeons and junior doctors. All patients who did not get surgery within 36 hours were reviewed by the multi-disciplinary team. Additionally, a hip fracture clinical nurse specialist carried out a separate monthly audit which looked at each delay to theatre, time to consultant review, length of operation and any patient deaths.

The trust did not participate in the National Ophthalmic Database Audit (NOD). The NOD collects and analyses a nationally agreed cataract surgery dataset for all ophthalmic services across England and Wales. The purpose of the audit is to benchmark standards of care and provide a tool to equip providers in meeting quality and improvement standards. The trusts electronic patient record system did not support the data collection required to meet the NOD standards.

The service took part in the National Cancer Patient Experience Survey (NCPES) for the urology service and scored above the national average satisfaction scores.

Relative risk of readmission - Lister Hospital

From September 2016 to August 2017, patients at Lister hospital had a higher than expected risk of readmission for elective admissions and a similar to expected risk for non-elective admissions when compared to the England averages.
Elective Admissions - *Lister Hospital*

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

- General surgery patients at Lister Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Lister Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery patients at Lister Hospital had a much higher than expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - *Lister Hospital*

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

- General surgery patients at Lister Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at Lister Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Plastic surgery patients at Lister Hospital had a much higher than expected risk of readmission for non-elective admissions when compared to the England average.

There were no action plans to address the outcomes which were worse than expected. The service told us that its national audit action plan required a review, and that this would be done as part of its quality transformation programme. We were not provided with any timescales of when this would be completed.

The service told us that trauma patients (that is, non-elective patients) were seen in the surgical assessment unit on the day of their injury and then, if their clinical condition allowed, they were sent home to wait for a planned surgical date. When they returned for surgery, this was recorded
as a readmission. However, this did not explain the higher than average number of readmissions for elective (planned) patients.

**National Hip Fracture Database**

The trust participated in the National Hip Fracture Database.

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.8% which and falls in the middle 50% of trusts. The 2016 figure was 6.4%.

The proportion of patients having surgery on the day of or day after admission was 77.4%, which was worse than the national aspirational standard of 85% and falls in the middle 50% of trusts. The 2016 figure was 82.9%.

The perioperative medical assessment rate was 94.9%, which failed to meet the national aspirational standard of 100% and falls in the middle 50% of trusts. The 2016 figure was 98.1%.

The proportion of patients not developing pressure ulcers was 94.5%, which falls in the bottom 25% of trusts. The 2016 figure was 97.4%.

The length of stay was 20 days, which falls in the middle 50% of trusts. The 2016 figure was 15 days.

*(Source: National Hip Fracture Database 2016)*

**National Bowel Cancer Audit**

The trust participated in the National Bowel Cancer Audit.

In the 2017 National Bowel Cancer Audit, the trust reported no patients undergoing a major resection. The 2016 figure was 83.1% patients undergoing a major resection had a post-operative length of stay greater than five days which was worse than the national aggregate.

The risk-adjusted 90-day post-operative mortality rate was 0%, that is there reports of death within 90 days, as none were performed. The 2016 figure was 3%.

The risk-adjusted 2-year post-operative mortality rate was 20.5% which was within the expected range. The 2016 figure was 17.9%.

The trust reported no figure for the risk-adjusted 30-day unplanned readmission rate as no bowel resections had been performed during the reporting period.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 60.0% which was within the expected range. The 2016 figure was 59.3%.

*(Source: National Bowel Cancer Audit 2017)*
National Vascular Registry

The trust participated in the National Vascular Registry (NVR) audit. The 2017 audit results showed the trust were achieving patient outcomes within the expected range or better than the national standard.

In the 2017 NVR audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% 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 5 days, which was better than the national aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 2.2%. This was within the expected range and similar to the national aggregate of 2.2%. The 2016 figure was 1.5%.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer Audit

The trust participated in the National Oesophago-Gastric Cancer Audit.

In the 2016 National Oesophago-Gastric Cancer Audit, poor quality data was provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The trust was not eligible for the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 33.8, which was significantly lower than 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 as 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)

The trust provided a response to this data. Some of the surgery included in this audit is carried out in neighbouring NHS trusts and therefore East and North Hertfordshire NHS Trust do not collect or collate this data. However, surgery services are aware of patient outcomes, which are discussed at regional network meetings and are reportedly in line with national averages.

National Emergency Laparotomy Audit

The trust participated in the National Emergency Laparotomy Audit (NELA).
In the 2017 NELA, the Lister Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 141 cases.

The Lister Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 71 cases.

The Lister 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 64 cases.

The Lister Hospital achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 39 cases.

The risk-adjusted 30-day mortality for the Lister Hospital was within the expected range, based on 141 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they felt 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:

- For groin hernias, performance was about the same as the England average.
• For varicose veins, performance was better than 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)

Competent staff

The service did not have robust processes in place to ensure staff were competent for their roles. Most staff had received an appraisal but not all had received the required training updates or received supervision to provide support and monitor the effectiveness of the service.

Patients were not always cared for by staff with the right skills and knowledge. Appropriate training and opportunities for personal and professional development were not always provided. Most all staff had undergone an appraisal. Appraisal rates across the division in February 2018 were 81% overall. Nurse appraisal rates were 83% and 93% for doctors. This was lower than the trust target of 90%. The trust told us it had an action plan to address the shortfall and that their target would be achieved by July 2018.

Some nursing staff had not received all relevant or required training. For example, blood transfusion training compliance was 83% in the surgical division. However, this figure includes the number of staff who have had blood training at some point, and it included staff who may not have had the required biannual training update or completed the mandatory competency based assessment every three years. For example, on ward 5A we saw that two nurses had blood transfusion training recorded for 2017, but all other nurses had dates for 2016 or earlier, and on SAU, blood transfusion training had been completed in 2009 in the one nurse record we looked at. Some nurses were confused about how often blood transfusion training was required. During the mandatory training day, a ‘blood transfusion awareness’ session was included. However, this did not include the practical aspects of blood administration.

Orthopaedic surgeons reported on the divisional risk register that they did not have the necessary training or skills to look after patients who had sustained a head injury on the orthopaedic wards. This had been on the risk register since April 2016 and no extra training had been provided.

Urology consultants reported that junior doctors and registrars did not always have the necessary skills and expertise required of their role. Consultants were required to be in theatre to assist and supervise junior doctors which meant they were not free to carry out their ward or clinic work. Urology registrars did not have dedicated time for emergency theatre cases and consultants said that they did not always have the necessary skills for emergency cases either. Consultants said this resulted in patient safety concerns. This was on the service risk register with a current risk rating of 12 and a review date of September 2018. However, there was no date recorded when this was entered onto the risk register and no actions recorded to mitigate the risks.

Nurses were not always trained in some skills. For example, nurses on Swift ward had not been trained and therefore did not have the required competency, to look after patients with a nasogastric tube, and only a few nurses in the surgical wards were trained in cannulation (insertion of a plastic tube into a vein to allow direct administration of fluids and medicines), or
phlebotomy (taking a blood sample). Nurses told us they had access to a phlebotomy service in working hours and that doctors were always available to either take blood or cannulate a patient when required. However, nurses told us about a serious incident where a cannula was required out of hours which nursing staff were unable to site and a doctor did not attend the ward to undertake this task either. This meant a patient went without essential medication overnight which resulted in harm.

In SAU, not all nurses and clinical support workers were trained in cannulation. Doctors told us this meant that they had to spend more time with each patient in SAU when they were often required to be somewhere with another patient. Nurses told us that new staff were currently being trained in cannulation.

We were told by senior nurses that training to use intravenous therapy pumps was provided by the trust’s electrical medical engineering board as part of its medical device training. This department kept a local register of staff who had attended pump training. Ward managers did not have a list of staff who had completed the training, or when. In addition, staff did not complete update training. This was not in line with trust policy which required ward managers to keep a record of all staff medical device (pump) training including each staff member’s annual self-certification of competence. The policy also required a quarterly audit of staff records to ensure that device training was updated in line with policy. We asked the service for its latest audit results and received a list of names of staff their ward or department and which device, who had undergone training provided by the engineering department in 2017 and 2018. However, it was unclear what percentage of staff had been trained in individual areas and we could not ascertain if all staff and all areas had been included.

Nurses completed as self-certification of their pump competency when they collected a pump from the equipment library. We did not see any evidence that only the nurse who collected the pump, used it while it was outside of the equipment library, and nor was this in line with the trust’s policy.

Nurse training was not always recorded and some training provided was informal. For example, experienced nurses demonstrated how to operate some medical devices and equipment to junior staff. However, there was no competency assessment follow up and records of the training were not always made.

Link nurses received extra training in specific areas. For example, there were link nurses for falls who had extra training and spent time with the falls lead nurse, and infection prevention and control link nurses who attended regular updates provided by the infection prevention control team.

We spoke with nursing students who were satisfied with the training opportunities provided in surgical services. Student nurses had a qualified nurse mentor who worked alongside the student regularly to ensure essential skills were learnt and safety was maintained. Nursing students had skills booklets and competencies to be achieved in each area.

There was a guide for new starters in the service which provided a list of training nurses should complete within their first year. Topics included pain management, wound management and discharge planning. There were also two surgery study days which covered general surgery topics, for example, anatomy and physiology and surgical emergencies. We also saw a detailed programme of training due to commence in April 2018, for managing acutely unwell patients. The programme included six full days of training and topics covered included, for example, sepsis, diabetic and cardiac emergencies.
All new staff attended an induction programme. This included both a trust wide induction and local induction. Nursing staff and doctors told us the induction was useful. The trust wide induction training included information governance, infection prevention and control and fire safety. The local induction included orientation to the department and a supernumerary period, where staff were supported to familiarise themselves with the local processes and practices. In the SAU, a newly qualified nurse showed us their preceptorship workbook and told us they had been supported well when they joined the service. However, two nurses in the surgical division told us they had not been fully supported when they had joined the service recently, one of whom had decided to transfer to another area due to lack of support.

Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely. However, clinical supervision was not formally provided or documented for nursing staff. The service told us a programme of clinical supervision was due to be rolled out in April 2018. However, during our last inspection in October 2016, we were told that clinical supervision was due to commence shortly after.

Nursing and theatre staff were offered opportunities to rotate within the surgical departments to improve their wider nurse skills.

Junior doctors were provided with supervisory training and reported good support from their consultants. Junior doctors attended scheduled training sessions and monthly audit days.

Nurses were encouraged to study for an MSc in contemporary nursing in order that they could become an advanced nurse practitioner. We were not provided with details of how this course would be funded or how many staff in surgical services had attended the course.
Appraisal rates
From April to October 2017, 74% 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 table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>238</td>
<td>317</td>
<td>75.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>27</td>
<td>36</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>132</td>
<td>177</td>
<td>74.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>8</td>
<td>11</td>
<td>72.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>133</td>
<td>186</td>
<td>71.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Multidisciplinary working
The multidisciplinary team did not always work together to benefit patients.
Doctors, nurses and other healthcare professionals mostly supported each other to provide good care. However, nurse staff shortages meant sometimes nurses were moved to other wards or departments to ensure patients were kept safe. Doctors and nurses had competing priorities.

A junior doctor told us that due to nurse shortages, they often had to complete the ward rounds without a nurse present.
Not all departments communicated adequately with each other. We saw an incident where the interventional radiologist had cancelled a patient procedure without first discussing this with the requesting consultant. The cancellation had resulted in moderate patient harm.

Effective multidisciplinary team working practices were in place in most areas. Relevant staff, teams and services were involved in assessing, planning and delivering patients’ care and treatment and generally worked together to understand and meet the range and complexity of patients’ needs. We observed patient care on surgical wards was supported by a variety of teams. This included pharmacists, physiotherapists, dementia nurses, and dieticians. Nurses told us how they worked together with dementia specialists to ensure all individual needs were met and the best care for patients was provided.

Staff told us about the arrangements they had made in the pre-admission unit in order to enable patients to attend for their appointments with their careers and other community staff, including specialist learning and disability nurses where necessary.

Some wards and clinical areas held daily huddles where all members of the nursing team met briefly to discuss plans for the day and any actions or concerns. However, on ward 5A, the huddle only included the two nurses who were in charge of each end of the ward.

Most staff reported good working relationships between doctors and nurses and we saw this during our inspection. However, in the SAU, some nursing and medical staff told us they often had competing priorities. For example, when it was busy in the department and nurses were caring for patients, doctors were required to take blood or insert cannulae. Doctors told us they were not based in the SAU and had to cover multiple wards and the emergency department so were often delayed due to ‘extra’ tasks. Doctors told us they were aware nursing staff in SAU were busy.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Most staff had access to an electronic records system that they could all update.

Observations of patients’ blood pressure, pulse, respirations and oxygen levels, were recorded electronically on hand held data pads and all staff working in the service had access to the data pads. Temporary staff were assigned a data pad at the beginning of their shift which was handed back to the nurse in charge prior to leaving the clinical area.

Some patient information was recorded on a new electronic system which staff told us was difficult to use. Some staff were waiting for training on the new device and could not access the system. Doctors told us the new system slowed them down when writing patient discharges.

Temporary staff were unable to access patients’ blood or microbiology results as these were stored on secure devices and only accessible to trust staff. We were told that there would always be a trust employed member of staff working with agency nurses who could access the system.

Seven-day services

Although the surgery directorate mostly provided services seven days a week some services were not available out of normal working hours and not all patients were assessed by a consultant. Registrars were able to admit and discharge patients.
The surgery directorate provided most services seven days a week. Seven day ward round and seven day emergency operating was available. However, not all patients in SAU were seen by a consultant or reviewed by one, daily. This did not comply with national guidance for seven-day services (NHS: Seven day Services Clinical Standards, 2017) priority clinical standard 6. However, registrars were able to admit and discharge patients.

Service leads told us doctors ward rounds were undertaken by the on-call team seven days a week. All patients were expected to have been seen by a consultant or registrar by mid-day. Deputy general managers or matrons escalated patients, who had not been seen by this time to a senior doctor.

Patients who had been admitted in an emergency were seen by the on-call team, which included a consultant or registrar. The service audited its compliance to consultant reviews in 24 hours and the most recent audit carried out in 2018, showed that this was achieved 95% of the time. However, the audit data did not distinguish between a registrar review and a consultant review.

Patients who had been admitted for elective (planned) surgery were seen daily by a registrar grade or equivalent or a consultant.

General and vascular surgery each had one commitment free consultant 24 hours a day, seven days per week to support on call and emergency work.

Consultants were on site from 8am to 6pm weekdays, and on call from home outside of these times. General surgery consultants were also available at weekends in the morning. However, urology, ENT, plastic, vascular and trauma and orthopaedic surgeons were not generally on site at the weekends.

Sufficient out of hours medical cover was provided to patients in the surgical wards and this included access to on site and on-call consultant cover. Consultants could be contacted out of hours by junior staff if required. Junior doctors and middle grade doctors we spoke with said the on-call consultants were responsive.

There was a dedicated emergency surgery theatre (known as a CEPOD theatre) on site. An anaesthetic consultant was on site weekdays from 8am to 6pm and during the morning at weekends. There was an on call from home rota outside of these hours. Theatre nursing staff were available 24 hours per day, seven days per week on an on call basis. This included anaesthetic scrub and recovery staff.

Interventional radiography (IR) and magnetic resonance imaging (MRI) were not available 24 hours a day, seven days per week. This did not comply with national guidance for seven-day services (NHS: Seven day Services Clinical Standards, 2017) priority clinical standard 6. In an emergency, patients requiring IR or an MRI scan were transferred to other NHS hospitals but there was no formally agreed pathway for the transfer. Data on the number of patients receiving IR and MRI out of hours was not collected by the trust. The service reported no instances of patient harm due to the unavailability of IR and MRI out of hours.

Other diagnostic services were available 24 hours a day, seven days a week. Staff we spoke with said they accessed them easily. From 9pm to 8am images were reported off site by an external provider and we were told there was no delay in reporting. Between 8am and 9pm a combination
of a separate external company and trust staff reported on images. Turnaround during working hours was dependent upon urgency of the request.

Physiotherapy services were provided by another NHS provider and were not routinely available at weekends. Saturday physiotherapy was available for orthopaedic patients only. There was no physiotherapy service on Sundays or bank holidays unless a member of staff volunteered. Nursing staff told us this was a problem for patients who had their operation on a Saturday as it meant a delay in getting some patients moving in a timely manner.

Dietitians, occupational therapists and speech and language therapists were not available at weekends for surgical patients.

The outreach service operated from 24 hours a day, seven days a week. The pain team operated from 8am to 6pm Monday through to Friday. Outside of these hours, there was an anaesthetist on call via a bleep.

Clinical pharmacists provided a ward based service during normal working hours and to five high-risk wards at the weekends for the remaining clinical areas, an out of hours system to obtain medicines was available, as well as access to an on-call pharmacist, if needed.

Health promotion

Patients attended pre-operative assessment appointments where their fitness for surgery was checked.

Patients having elective surgery were provided with a booklet of advice about their hospital stay. Patient information leaflets were provided on health promotion and guidance including dietary advice, smoking cessation and alcohol consumption.

The physiotherapy staff saw patients who were to undergo orthopaedic surgery. These appointments provided health promotion opportunities, including how to maintain mobility.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, most staff did not have training in the Mental Health Act 1983 and the Mental Capacity Act 2005.

Nursing staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Nurses understood when a person might need to be assessed for a Deprivation of Liberty Safeguard (DoLS) and understood what might constitute a deprivation of liberty. Some staff knew how to submit an urgent and a routine request for authorisation for DoLS. Staff we spoke with knew where to get advice on DoLS.
There were no patients subject to DoLS during our inspection. Ward staff told us they clarified a patient’s DoLS status in their shift handover meetings, so all staff were aware. The trust had a process in place to prompt staff to re-assess a patient’s capacity if it appeared this might change.

Medical staff supported patients to make decisions in line with relevant legislation and guidance. Doctors we spoke with were aware of MCA and DoLS requirements and told us they had received training. Nursing staff were aware of processes of how to support medical staff to assess and record decisions about care and treatment if patients lacked mental capacity and how to make ‘best interest’ decisions. We saw completed mental capacity assessments documented in the healthcare records appropriately.

**Consent was not consistently undertaken in line with the trust consent procedure.**

The trust had a consent policy to guide staff. There were procedures in place for patients who were assessed as not having mental capacity to consent to treatment. There was a specific consent form to be used that required two doctors’ signatures which was used for patients who were unable to consent themselves. Doctors we spoke with had a good awareness of the different types of consent and told us when they had completed ‘consent 4’, for patients unable to consent for themselves. However, the trust told us about an incident where consent was not gained prior to surgery, when the planned operation did not take place because other findings after the patient had been anaesthetised over rode the original plan.

The trust carried out a retrospective audit of consent in July 2017, which looked at 31 patient records across the whole trust. Results showed four sets of patient notes did not contain a consent form; two of these were from surgical specialities (ENT). The consent form was signed by the patient in only 85% of the 31 cases that the audit looked at and signed by the healthcare practitioner in only 37% of the cases looked at. Only 7% of patients received an information leaflet about their operation and only 10% of patients were given follow up contact details. This was not in line with the trust’s consent procedure. Findings from the audit were due to be presented at the rolling half day audit and governance meeting in April 2018 and a further audit was agreed for the future. We were not provided a date of when the audit was due by.

Staff told us that elective patients with a learning disability or those living with dementia were involved in a pre-operative meeting with their carer and consultant in order to put a plan in place for their admission. Carers were encouraged to stay with the patient and operating lists were adjusted to suit patient need.

**Mental Capacity Act and Deprivation of Liberty training completion**

During our inspection we asked staff about training they had received in MCA and DoLS. Most nursing staff said they had not attended this training but that they were aware it was available. Some nurses had booked to attend a face to face training session and some nurses told us the training was available online. We were shown a list of training dates advertised on the intranet. However, a trust representative told us MCA and DoLS training was covered in safeguarding training and that current compliance to safeguarding training was 94% for nurses and 75% for doctors. We were not assured that all staff had received the required training in MCA and DoLS.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. Staff promoted privacy, and patients were treated with dignity and respect. Staff members spent time with the patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients’ privacy and dignity during personal care, for example, staff pulled curtains around the bed space. We observed staff adjusting a patient’s bed clothes in order to maintain their privacy.

All surgical wards displayed many thank you cards, which they had received from patients and relatives. One person wrote, ‘staff on this ward without exception, have been kind and courteous’ and another said that they would ‘change nothing’. Another patient commented ‘nursing fantastic, food ladies fantastic’.

Friends and Family test performance

The Friends and Family Test response rate for surgery at East and North Hertfordshire NHS Trust was 51%, which was better than the England average of 29%, from December 2016 to November 2017.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

Theatre staff that were with patients before their anaesthetic were kind and reassuring and understood the emotional stress of having an operation and an aesthetic. Post-operative care within the recovery area was empathetic and staff did everything they could to ensure patients were comfortable and free from any pain. Ward staff listened attentively while they provided direct patient care.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients told us that nurses explained what they were doing, and asked for permission and agreement first. Patients said medical staff explained plans for their treatment and provided
opportunities to ask questions, this included family members when required. Patients in the pre-operative assessment unit were encouraged to bring family members to the appointment to ensure they were aware of any post-operative care that might be required at home. Physiotherapists and occupational therapists discussed post-operative care with patients and relatives to ensure a smooth and safe discharge home.

Patients said they felt involved in their care. The views and preferences of patients were taken into account in most areas. Most patients were very complimentary about the way they had been treated by staff. We observed most staff introduced themselves to patients.

We saw nursing staff encouraged those close to patients to be involved in their care. Patients and relatives knew which doctor was looking after them.

Staff assessed patients’ communication needs to ensure patients and staff understood each other. Patients who were assessed as requiring different communication methods had a yellow flag attached to their electronic patient record. Any patient with a yellow flag was required to have a dementia and delirium assessment completed within 72 hours of their admission and before discharge. They were also provided with a yellow wristband. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting the information requirements and communication needs of patients, where those are related to a disability, impairment or sensory loss.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

*The trust planned and provided services in a way that met the needs of local people.*

During the inspection, patient privacy was clearly of paramount importance to the service and we saw that patients were nursed in single sex bays with designated toilets and bathrooms. The service confirmed there had been no single sexed occupancy breaches from October 2017 to March 2018. Single sexed occupancy means that male and female patients do not share the same bay.

Adjustments were made for patients living with a physical disability, which included wheelchair access, lift, patient moving, and handling equipment and facilities for bathing. The treatment centre and the main hospital had disabled access in the main reception areas.

The wards had long periods of time, most of the day, when they were open to visitors. The wards protected mealtimes to ensure patients could eat their meals without interruption. Family members were encouraged to attend at lunchtime if the patient required assistance with eating so that they could provide support.

The purple butterfly symbol was used throughout the hospital to support patients and their families, and friends, who were approaching their end of life. There were butterfly volunteers based within the hospital who provided care and support where needed within the surgical wards.

The service understood the different needs of the local people it served. Staff acted on the needs of local people to plan, design, and deliver services. For example, the surgical division had started
weekend operating lists to reduce the time from referral to treatment and patients waiting over 52 weeks.

**Meeting people’s individual needs**

**Services were planned to take into account the individual needs of patients.**

Services were planned to take into account the individual needs of patients. For example, information from pre-operative assessments were clearly recorded, which included patients individual care needs and their medical conditions.

There were specific admission checklists and discharge planning tools for patients living with a learning disability. Appropriate arrangements such as arranging occupational therapy home visits were put in place for older patients with complex needs. During our inspection, we observed nurses discussing discharge plans with patients and their relatives.

Staff had access to translation services such as language and sign language interpreters. Staff spoke with could explain how they would book an interpreter. Information was also available in braille if required.

The acute liaison mental health team based within the hospital provided psychiatric support to patients. Staff knew how to contact the mental health team when required.

Staff could access specialist dementia nurses who were able to give expert practical, clinical, and emotional support to families of patients living with dementia. Patient documents were used which enabled staff to provide individualised care.

Patients living with a learning disability or dementia were encouraged to discuss their personal preferences with staff, for example we saw on ward 8B a nurse asking a patient with dementia what she would like to be called so they could provide a more personalised approach.

Reasonable adjustments were made to take into account the needs of different people on the grounds of religion, disability, gender, or preference for example staff on ward 11B informed us that side rooms would be offered to patients who had undergone or were transitioning through gender reassignment.

Staff on ward 11B explained that they had received some training in the care of patients who had undergone or were transitioning through gender reassignment and were confident that the patient’s needs would be met.

There were arrangements that supported the emotional and spiritual needs of patients. Patients and their relatives had access to the hospital chapel and chaplaincy offices. Patients from other faiths were also accommodated. For example, we saw the service had a Muslim prayer room available to support patients’ individual needs when required.

Staff ensured that correct standards and safeguards were in place when giving out patient information to family and friends, as recommended in NICE QS15 statement 13. For example, we observed a nurse asking the patient’s permission to discuss his care with a family member. The patient agreed a password and their family to ensure information was not given out inappropriately.
All staff wore name badges to help visitors and patients clearly identify who they were talking with. Notification boards in patient areas displayed pictures of staff uniforms so patients and relatives knew healthcare professionals’ nursing grades.

**Access and flow**

**Patients could not always access the service when they needed it. Waiting times for treatment were not in line with good practice.**

Services were planned in way that ensured elective surgical patients were allocated a surgical bed. At the time of the inspection, there were no surgical outliers. Surgical outliers is a term used when there are not enough surgical beds for surgical patients meaning these patients are cared for in another speciality bed, usually on a medical ward.

The service had a surgical assessment unit (SAU). Access to the SAU was by GP referral. At the SAU patients were assessed, treated and either admitted or discharged home. This helped patients avoid attending the accident and emergency department.

Patients with a fractured neck of femur had timely access to theatres. National guidance from the National Institute of Health and Care Excellence (2011) Clinical Guideline 124 entitled 'hip fracture management' recommends patients with a fractured neck of femur should be taken to theatre within 36 hours of arrival in the emergency department or diagnosis. The table below shows that the trust performed better than average for this metric.

**Hip fracture access percentage to theatres**

<table>
<thead>
<tr>
<th></th>
<th>National hip fracture database average</th>
<th>East and North Hertfordshire trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2107</td>
<td>68.2%</td>
<td>83.7%</td>
</tr>
<tr>
<td>September 2017</td>
<td>68.5%</td>
<td>79.3%</td>
</tr>
<tr>
<td>October 2017</td>
<td>70.4%</td>
<td>84.8%</td>
</tr>
<tr>
<td>November 2107</td>
<td>71.5%</td>
<td>87.9%</td>
</tr>
<tr>
<td>December 2017</td>
<td>70.2%</td>
<td>87.1%</td>
</tr>
<tr>
<td>January 2018</td>
<td>73.6%</td>
<td>83.7%</td>
</tr>
</tbody>
</table>

(Source: additional evidence request DR18)

There was an on-call theatre service in order that any patients who required emergency surgery could be operated on promptly. Consultants from each speciality were on-call at night and weekends and could support emergency procedures if required by more junior staff.

The NHS Constitution sets out that “patients wait no longer than 18 weeks from GP referral to treatment (RTT)”. However, due to the implementation of a new patient administration system in September 2017, senior staff within the division could not assure us that patients had not been delayed being diagnosed and treated within the required timescale. When we spoke with the
executive team, it was clear there was control over patient tracking lists and harm reviews had been carried out.

As a consequence of this, the trust had to use a manual system to track patients and carry out harm reviews. Although the executive team had oversight of this, the senior surgical managers did not have any knowledge with regards to patients waiting or whether harm reviews had been undertaken.

The trust had developed a stabilisation plan in February 2018, which planned and outlined actions to ensure essential clinical data, could be accessed. This supported the implementation of the new administration system, which tracked patient waiting times. Weekly meetings were held to ensure patient information was gathered and that patients were contacted regarding their treatment.

There were potential risks that some patients may have missed appointments due to the inconsistency in the new patient administration system. The trust had implemented a leaflet that was given to patients advising them to contact the trust if a follow up appointment had not been sent. Following our inspection, systems had been implemented to ensure that missing appointments were monitored and that patients received the correct information.

**Average length of stay**

**Trust Level – total elective and non-elective patients**

From October 2016 to September 2017, the average length of stay for all elective patients at the trust it was 2.3 days, which is lower than the England average of 3.3 days. The average length of stay for all non-elective patients at the trust it was 3.9 days, which is lower than the England average of 5.0 days.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for different specialties](image)

*Note: Top three specialties for specific trust based on count of activity.*

From October 2016 to September 2017:

- The average length of stay for trauma and orthopaedics elective patients was 2.9 days, which is lower than the England average of 3.3 days.
- The average length of stay for urology elective patients was 1.8 days, which is lower than the England average of 2.0 days.
- For general surgery elective patients, the average length of stay was 3.8 days, which is higher than to the England average of 3.3 days.
Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017:
- The average length of stay for general surgery non-elective patients was 3.7 days, which is lower than the England average of 3.9 days.
- The average length of stay for plastic surgery non-elective patients was 1.4 days, which is lower than the England average of 1.6 days.
- The average length of stay for trauma & orthopaedics non-elective patients was 8.1 days which is lower than the England average of 8.9 days.

Lister Hospital - total elective and non-elective patients

From October 2016 to September 2017 the average length of stay for all elective patients at Lister Hospital was 2.3 days, which is lower than to the England average of 3.3 days. The average length of stay for all non-elective patients at Lister Hospital was 3.9 days, which is lower than to the England average of 5.0 days.

Elective Average Length of Stay - Lister Hospital

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017:
- The average length of stay for trauma & orthopaedics elective patients at Lister Hospital was 2.9 days, which is lower than the England average of 3.3 days.
- The average length of stay for urology elective patients at Lister Hospital was 1.8 days, which is lower than the England average of 2.0 days.
- The average length of stay for general surgery elective patients at Lister Hospital was 3.8 days.
days, which is higher than the England average of 3.3 days.

Non-Elective Average Length of Stay - Lister Hospital

![Bar chart showing average length of stay for different specialties at Lister Hospital and England average.](image)

*Note: Top three specialties for specific trust based on count of activity.*

From October 2016 to September 2017:
- The average length of stay for general surgery non-elective patients at Lister Hospital was 3.7 days, which is lower than the England average of 3.9 days.
- The average length of stay for plastic surgery non-elective patients at Lister Hospital was 1.4 days, which is lower than the England average of 1.6 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Lister Hospital was 8.1 days, which is lower than the England average of 8.9 days.

*Note: Top three specialties for specific trust based on count of activity.*

(Source: Hospital Episode Statistics)

Referral to treatment times for oral surgery and trauma and orthopaedics were significantly below the England average.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From December 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the national average. The chart shows no data since September 2017 which was when the trust rolled out a new patient administration system. This has affected some data submission.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>88.8%</td>
<td>83.1%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>84.9%</td>
<td>72.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>82.0%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73.5%</td>
<td>72.8%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>69.4%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>47.5%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>39.9%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>0%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>70.5%</td>
</tr>
</tbody>
</table>

The 62 day target for urgent referral to treatment was consistently not met; with the 62 day referral to treatment from screening met for two of the six months from August 2017 to January 2018.

The service’s cancer 62-day standard was not being met. The Department of Health (DoH) has set a standard whereby 85% of patients should start their first definitive treatment for cancer within 62 days of their initial referral.

The trust board assured us that no surgical cancer patients had been cancelled due to the lack of surgical beds.
Trusts Cancer performance August 2017 – January 2018

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2 week GP referral to 1st outpatient</td>
<td>93%</td>
<td>97.6%</td>
<td>97.3%</td>
<td>97.1%</td>
<td>97.6%</td>
<td>97.6%</td>
<td>97.5%</td>
</tr>
<tr>
<td>2 Week wait - Breast symptoms</td>
<td>93%</td>
<td>93.3%</td>
<td>91.3%</td>
<td>90.1%</td>
<td>96.2%</td>
<td>92.3%</td>
<td>94.4%</td>
</tr>
<tr>
<td>31 day second or subsequent treatment (Anti-Cancer Drug Treatments)</td>
<td>98%</td>
<td>96.7%</td>
<td>95.6%</td>
<td>98.4%</td>
<td>95.6%</td>
<td>99.0%</td>
<td>90.5%</td>
</tr>
<tr>
<td>31 day second or subsequent treatment (Surgery)</td>
<td>94%</td>
<td>86.5%</td>
<td>92.1%</td>
<td>74.1%</td>
<td>96.8%</td>
<td>80.8%</td>
<td>84.6%</td>
</tr>
<tr>
<td>31 day second or subsequent treatment (Radiotherapy Treatments)</td>
<td>94%</td>
<td>94.7%</td>
<td>88.5%</td>
<td>69.5%</td>
<td>89.9%</td>
<td>93.7%</td>
<td>88.0%</td>
</tr>
<tr>
<td>31 day diagnosis to 1st definitive treatment for all cancers</td>
<td>96%</td>
<td>92.1%</td>
<td>93.9%</td>
<td>91.6%</td>
<td>96.3%</td>
<td>96.4%</td>
<td>95.3%</td>
</tr>
<tr>
<td>62 day referral to treatment from screening</td>
<td>90%</td>
<td>55.6%</td>
<td>94.4%</td>
<td>57.9%</td>
<td>77.8%</td>
<td>92.3%</td>
<td>42.9%</td>
</tr>
<tr>
<td>62 days urgent referral to treatment of all cancers</td>
<td>85%</td>
<td>69.5%</td>
<td>73.2%</td>
<td>76.8%</td>
<td>75.5%</td>
<td>79.9%</td>
<td>71.4%</td>
</tr>
</tbody>
</table>

(Source: additional evidence request Cancer performance January 2018 DR 392)

Discharge planning was started on admission to the ward this included an estimate of the patient’s length of stay, together with any additional required support following their procedure. Whiteboards on the wards displayed the estimated discharge date (EDD) for each patient, which was discussed during safety huddles.

Within the months of January to March 2018, utilisation of the operating theatres were below the trust’s planned activity of 600 hours per month against the actual hours of operating which were 400 hours per month planned activity was measured between 8am -6pm. The overall capacity usage within this period was recorded at 34%. Senior theatre staff said that theatre utilisation was being monitored and improvements were being pursued.

We spoke with senior theatre staff who told us they had introduced a process where patients
were placed on a short notice waiting list. There was a list of patients who had agreed to be available at short notice and were contacted to come in for their operation therefore improving usage within the operating theatre departments.

**Cancelled operations**
Since the end of 2016 the number of patients whose operations was cancelled and not treated within 28 days has been higher than the England average.

During our inspection, we observed medical outliers on surgical wards due to lack of capacity for these patients. Staff told us that this had impacted on elective surgery, due to the lack of surgical beds patients had their operations cancelled.

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.

The latest information for Q2 2017/18 shows this trust to have cancelled 88 surgeries. Of the 88 patients whose surgeries were cancelled, 22 were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days]

Over the two years, the percentage of cancelled operations at the trust showed an upward trend with a peak in the latest quarter, Q2 2017/18. Before Q3 2016/17 the trust was performing better than the England average but since then the number of patients whose operations were cancelled and not treated within 28 days has been higher than the England average.

**Cancelled Operations as a percentage of elective admissions**
Over the two years, the percentage of cancelled operations at the trust showed a general trend of improvement. The percentage of cancelled operations at the trust has been higher than the England average for all quarters apart from Q3 2016/17. Cancelled operations as a percentage of
elective admissions only includes short notice cancellations.

(Source: NHS England)

[Graph showing percentage changes]

Learning from complaints and concerns

Although the service generally treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff, not all complaints were investigated in a timely manner.

We discussed complaints with the surgical management team. Staff across the service were familiar with the trust complaints policy. A complaints report and the timeliness of investigating and responding to complaints were discussed amongst senior staff at clinical meetings.

Nursing staff understood the process for receiving, handling and responding to concerns and complaints. Staff reported complaints as an incident on the trust's electronic incident reporting system.

Patients we spoke with knew how to raise concerns and make formal complaints. Posters detailing how to make a complaint were displayed on the wards and information was provided in leaflets for inpatients. Patients told us the nursing staff were approachable and if they wished to raise a concern they would do this by speaking with the nurses who were caring for them at that time.

The hospital had a patient advice and liaison service (PALS) which patients could access if they wished to raise a concern.

All feedback received was reviewed. Staff discussed and agreed their actions in response to patient and carer feedback. Each ward had a ‘learning from your experience’ poster to display their ‘you said – we did’ actions. The ward manager updated the ‘you said – we did’ action posters each month.
Staff told us complaints and learning from complaints were shared and discussed at handovers and staff meetings. We saw communication books in place on the surgical wards, which contained patient comments and complaints. However, there was no evidence to suggest that staff regularly read these comments.

**Summary of complaints**

From November 2016 to November 2017 there were 162 complaints about surgical care which is the second highest across the trust. The trust took an average of 45.8 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed in 30 days of receipt of the complaint.

**Complaint breakdown by site:**

- **Lister Hospital:** There were 155 complaints which took an average of 44.2 days to complete and close.
- **QEII Hospital:** There were seven complaints which took an average of 73.9 days to complete and close.

These were most commonly in relation to treatment received, communication and waiting time.

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

The Trust has set a timeframe of ‘80% of complaints are replied to within the timeframe agreed with the complainant

**Is the service well-led?**

**Leadership**

The trust had managers at some levels with the right skills and abilities to run a service providing high-quality sustainable care. However, not all leaders had the necessary experience, capability, or capacity to lead the service effectively. In addition, many of the senior nursing staff had dual roles which distracted them.

A divisional director of surgery who reported to the chief operating officer and a divisional chair of surgery led the surgery service. Two general managers (one acting), a head of nursing and a theatre operations manager formed part of the senior leadership team. There were eight matrons who each had specific areas of responsibility including clinical work. For example, one matron was the lead nurse for ophthalmology and one was lead nurse for urology and matron for ward 7b. The matron in SAU also looked after ward 11b, the outreach team, and the ENT nurses. The theatre operations manager had two theatre managers who worked clinically on some days. Most surgical specialities had a service coordinator.

Divisional leaders told us they had a good working relationship with each other and were each dedicated to their role and responsibilities. Matrons were supported in their role by ward managers.
Ward managers told us their matrons were supportive. Most matrons did not visit their clinical wards every day due to their other work commitments. Ward managers said they could contact the matron at any time if required. Nursing staff knew who their matrons were and how to contact them. However, during our four day inspection of surgery services, we saw only one matron, and we were not assured about their daily visibility and accessibility for staff and patients. Some matrons had diverse portfolios and were unable to dedicate sufficient time to each of their roles and responsibilities.

Senior divisional leaders and local leaders understood some of the challenges they faced around quality and sustainability of services, including, financial pressures, bed capacity and staffing issues. Divisional leaders were committed to addressing the challenges and had identified some actions to make improvements, for example, Saturday theatre lists to reduce waiting times. However, senior leaders had little insight into how these challenges affected staff delivering care daily. For example, we saw that ward managers were unaware of the training requirements for each member of their team, and that hand hygiene compliance was poor in their area. Divisional leaders did not appear to relate patient safety incidents to the pressure clinical staff were under. Staff told us every day was a ‘battle’ due to staff shortages. One told us they dreaded it when matrons appeared in their ward as it meant staff were going to be moved to another area. The junior staff we spoke with did not see matrons as supporting them as individuals, as a team or their department. However, nursing and clinical support workers told us that ward managers and junior sisters were approachable and supportive and offered advice and provided training opportunities when required.

Leaders were not always clear about their accountability for quality. For example, ward managers did not ensure the resuscitation trolley was checked every day and nurses on their wards did not follow the medicines management policy when administering intravenous medicines. This demonstrated that leaders were not always aware of risks, or did not control them well.

Managers met regularly to support each other, to share learning and information and to improve communication between the wards and departments. Ward managers arranged meetings with their band 6 staff to cascade important information. However, only ward 8b had held a staff meeting for their whole team in the previous three months. Managers said they expected the band 6 staff to pass on any relevant information to the rest of the team. There were various methods of communication across the teams, including meetings, newsletters, whiteboards, notice boards, and email.

Ward managers were not allocated any administrative support to help organise staff training, or write meeting minutes and staff notices.

Ward managers and matrons did not always demonstrate they had the necessary skills to plan staff rotas effectively. We saw incidents had been reported due to shortages of staff when two agency nurses were booked to work alone on a ward during night shifts, or when junior nurses were left alone on wards and when planned annual leave had not been taken into account and wards were left with less staff than required.

Managers were involved in the recruitment of new staff for their areas and we saw that they had attended recent recruitment days in order to fill vacant posts.

The trust did not have a leadership and talent strategy in place. However, there was specific training at some levels to enable staff to carry out their leadership role effectively. For example, for
staff nurses there was ‘nurse in charge training’, for band 6 nurses, there was attendance management training, and ward managers were encouraged to undertake a leadership course. Some senior nurse leaders we met had not undertaken any recent leadership training.

**Vision and strategy**

There was no vision or strategy for surgical services. However, the trust had a vision for what it wanted to achieve and plans to turn it into action, developed with involvement from some staff, patients, and key groups representing the local community.

There was no vision for surgical service in place at the time of our inspection. Clinical staff we spoke with were not generally aware of the trust vision or strategy and said they had not been involved in its development. Not all leaders were held to account for the delivery of the strategy or vision.

Surgical services did not have a separate strategy from the rest of the trust. The trust strategy was to:

- Keep our promise on value and quality
- New services and new ways of caring
- Re develop Mount Vernon cancer centre

The trust vision was ‘to be amongst the best’ for patient experience, financial stability, clinical outcomes, and patient safety.

**Culture**

Not all managers across the service promoted a positive culture that supported and valued staff, and created a sense of common purpose based on shared values. Staff satisfaction was mixed and some staff did not feel empowered. Some teams worked in silos and did not work cohesively together.

The trust values were:

- putting patients first
- we strive for excellence and service improvement
- we value everybody
- we are open and honest
- we work as a team

Some staff of all grades told us they knew what the trust values were. Clinical staff were not aware of how these values were chosen.
Most nursing staff in the surgical departments reported a good culture in their own ward or unit. Staff felt supported by their immediate colleagues, managers, and matrons in their individual areas. Medical staff said they were supported by more senior colleagues.

Nursing staff we spoke with said their line manager tried to look after their welfare, although they did report feeling an increase in stress due to insufficient staff, from being left alone with junior colleagues or with agency nurses, and from being moved to other clinical wards regularly. However, most staff told us they were generally happy with their work and their immediate team. Staff felt listened to by their manager and said they worked well together.

Nurse staff development was not always a sufficiently high priority. Appraisals had not been undertaken on all staff, for example on ward 5b in February 2018, only 47% of staff had an in date appraisal. Formal clinical supervision was also not provided.

Leaders in the theatre department reported that some allegations of bullying had been reported via a third party. In response, the department held four drop in sessions for staff to talk confidentially about any concerns they had and also opened a suggestion box where comments could be left anonymously. The sessions were well attended by theatre staff and no one had reported bullying.

Openness and honesty was generally encouraged and nursing said they felt able to discuss and escalate concerns without fear of retribution. However, results from the most recent staff survey indicated staff confidence in reporting incidents had declined. We found that not all serious incidents were reported or discussed openly with staff, or in a timely manner. We were told about a never event which had not been reported on the trust’s incident reporting system for 20 days, although many staff were aware that the incident had occurred. This was not in line with trust policy which required all incidents to be reported immediately, or as soon as is practically possible.

Matrons told us they had 60 days to investigate a serious incident and write a report. Learning from these incidents was only shared after the report had been accepted. This meant learning from serious incidents was delayed. Nurses told us they were aware of brief details surrounding some recent serious incidents but that they had not been told about the events officially. Serious incidents, once fully investigated, were shared via a monthly trust wide publication, ‘patient safety matters’.

Clinical staff we spoke with said they understood their responsibilities with regard to the duty of candour legislation. Nursing and medical staff were aware of the duty of candour and described a working environment in which any mistakes in patient’s care or treatment were investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. However, we found that duty of candour had not been applied for patients who were waiting longer than expected for treatment. The service had not contacted patients waiting for surgery to explain the long wait, or who to contact if their condition deteriorated while they waited for surgery.

The trust did not provide staff with recognition of achievement awards. However, we were told some wards in the surgical division had recently started a recognition scheme where they nominated one member of staff each month as ‘carer of the month’. 

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Governance

The service did not have a fully embedded systematic approach to continually monitor the quality of its services. There were unacceptable levels of serious incidents and never events, and the service had no clear oversight of all patients waiting for surgery.

Surgical services had a divisional framework for governance arrangements. The clinical governance committee met monthly and fed into the divisional board. The committee consisted of the deputy divisional chair, the head of nursing, matrons and a general manager or their deputy. We saw an action log of these meetings where quality issues, such as complaints, incidents, and audits were discussed.

Governance focus and oversight on the surgery service was not consistent. This meant that key governance issues were not identified or addressed through the governance processes within the division. For example, the service had received 134 formal complaints for surgery in three months from October to December 2017, of which, 82 remained open. The correlation of complaints, the increased numbers of cancelled surgeries, and waiting times had not been correlated or discussed during governance meetings. This meant that there was no improved learning from these complaints that were continuing to increase in number. The service leads were also not aware that this was a risk for the service.

There was a lack of joined up governance and oversight around patients waiting for surgery. Divisional leaders told us they were unable to say how many patients had breached waiting times for treatment. This was due to poor data collection which had been caused in part, by a new patient information system and non-compliance to standard business processes. Consequently, the division were aware that not all patients had been assessed for harm caused by delays to their treatment. This was on the service risk register.

We asked the service about their outstanding serious incidents (SI) and how they were monitored. We were provided with a document which outlined a new SI process, which consisted of a twice weekly SI review panel meeting. The panel was to include the director of nursing and the medical director and the trust patient safety lead. At the time our core service inspection, this review process had not been instigated. However, during our well led inspection five weeks later, this process had commenced.

Some information was shared between ward level and divisional level. Matrons audits were discussed at monthly divisional meetings and results were available for the governance team to view via the electronic reporting dashboard. However, most of the information provided in the matron’s audits was gathered by the ward nursing team and there was no reliable system of verification. For example, during our inspection, we observed staff did not always follow the trust’s hand hygiene policy and we saw instances where staff of all grades did not carry out hand hygiene in line with good practice. However, from January to March 2018, results from the services’ hand hygiene audits were mostly 100% compliant. We were told matrons did peer review audits using nursing sisters to check each other’s wards. We also saw there was a delay in reporting serious incidents which meant that divisional governance leads were not always made aware of governance issues in a timely manner.

There were some governance processes in place to ensure the trust board and the clinical commissioning group were sighted on ward level quality audits. Most nursing staff were aware of
their own quality audit performance but were not aware of results from other surgical wards and departments. Some audits undertaken in the service had a poor compliance. In addition, these audits were not always followed up with action plans to improve future performance. For example, actions to improve discharge summaries.

Senior leaders within the surgical division attended trust wide meetings, such as clinical audit meetings, serious incidents meetings, morbidity and mortality meetings, and patient experience meetings. They also attended the trust’s quality governance committee on a quarterly basis to discuss key divisional risks and mitigations.

The divisional director of nursing for surgery held regular meetings with matrons. Surgical ward managers and sisters had monthly meetings with matrons to discuss vacancies, incidents, complaints and local audits. We saw some minutes of meetings where incidents, complaints, and performance issues had been discussed. However, most ward managers did not hold regular team meetings with all their nursing team and it was band 6 sisters who were responsible for cascading any relevant information to band 5 nurses and clinical support workers.

There were some arrangements in place with partners and third parties. For example, head and neck cancer services were provided by another local NHS trust, as was employment of allied health professionals. The monitoring of service level agreements with third parties was managed by the contracts department and any issues identified were highlighted to the divisional board.

**Management of risk, issues and performance**

Not all systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were effective. Risks, issues, and poor performance were not always identified or dealt with appropriately or quickly enough.

There was a risk and quality committee which met on a quarterly basis. Risks were reviewed at speciality level and divisional level meetings. The highest rated risks were escalated to the trust’s clinical governance committee. However, individual clinical areas did not hold location specific risk registers and ward managers were generally unaware of any recorded risks for their areas. Ward managers told us nurse staffing was their biggest risk. This was not on the surgical risk register. We were not assured that local areas had their own risk registers or that ward and theatre managers where involved in the reporting and monitoring of risks.

There were some systems in place to identify, record, manage and escalate risks. Risks to surgery were recorded on the surgical divisional risk register. Some risks had been on the service risk register for several years and had very few updated actions. Some risks on the register had no date of opening recorded and it was impossible to know when the entry had been made. For example; ‘risk to trauma patients due to inadequate theatre capacity’.

Many of the risks on the risk register were related to old, inadequate, or insufficient equipment, and could only be addressed by additional funding. Service leaders told us additionally funding was difficult to obtain due to the trust’s financial circumstances and the ‘grip and control’ programme which was in place.

The trust told us that its surgical risk register monitoring process was being updated and that the risk register provided to us was outdated. For example, dates of risk entry were not recorded on the risk register we saw. We were told there was a new risk register procedure in place from
March 2018, which required a lead from surgery services to review the risks in their division at a ‘risk clinic’. The plan stated that this would be led by the medical director and nursing director. We were told that the surgery risk register had recently been reviewed to test for accuracy and legitimacy of the content and associated risk scores. The new planned governance arrangements ensured this revised register was reviewed. This was a new process, and we were unable to assess its effectiveness at the time of our inspection.

Not all risks, issues, and performance shortfalls were reduced sufficiently to avoid patient harm. We were not assured that systems designed to reduce risk were adequate to ensure patients were kept safe at all times. Some risks were on the risk register with no updated actions and some risks had not been included in the divisional risk register. For example, nurse staffing in surgical services. From September 2017 to March 2018, there were 87 incidents reported due to staff shortages, which staff believed impacted on their ability to care for patients safely. We looked at an incident report where nurses had requested extra staffing to assist with a vulnerable patient. The ward was on ‘red alert’ for staffing, which meant there was insufficient staff to safely look after patients. Despite this, extra staff were not provided and a vulnerable patient fell and broke their hip. Staffing was raised as a concern during our inspection in October 2015 and it had not improved during this inspection.

Other risks not included on the risk register included the lack of emergency buzzers in some wards; confidential patient information not stored securely. In addition, there were risks associated with failing to carry out VTE risk assessments on all patients, despite a serious incident which had resulted in death due to a pulmonary embolism after a patient was not prescribed or given any medication to prevent a VTE.

There had been no impact assessment in SAU on the risks associated with accepting GP referrals directly into the department without additional resources. This was a new service which commenced in December 2017. Staff in the department told us the extra work generated by GP referrals put patients at risk.

Guidelines to ensure patient safety were not always followed which meant some risks were not recognised or mitigated against. For example, when the trust ran out of beds, operations staff, rather than clinical staff, made decisions about where a patient could be safely cared for. We saw an incident had been reported where a critically ill patient had been sent to a ward to be nursed in a corridor. In addition, staff did not always follow the trust’s health records management policy which stated confidential patient notes must only be accessible to authorised staff. However, following our inspection, the trust addressed this and removed patient records from areas where the public had access.

Not all serious incidents were investigated in a timely manner and opportunities for learning were delayed. In March 2018, 18 serious incidents were open, three of which had been open for 12 months and three had been open for six months. There was no one designated leader in the surgical team who had clear oversight of all serious incidents. Nursing staff told us they did not always get feedback from the incidents they raised. This was identified during our inspection in 2016 and it had not improved.

There was a systematic programme of clinical audit. However, we saw many of the audits had not commenced, despite completion dates required by 31 March 2018. Clinical and internal audit
processes were inconsistent in their implementation and their impact. For example, we saw some wards did not return data for the matron’s quality audit, and some clinical audits had not been started. We saw that an audit of consent carried out in July 2017 was not scheduled for presentation until April 2018 and the only action following the audit, was to repeat it later in the year, despite the findings that indicated the trust consent policy was not always being followed.

The infection prevention and control committee provided annual reports to the board. The most recent report from January 2018 did not contain any action plans where infection control audit compliance was lower than expected.

**Information management**

The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. However, some information collected was not accurate or reliable. Different information management systems were used in the hospital which were not compatible with each other. Some confidential patient information was not stored securely.

The trust was aware of some issues with the quality of their data. Systems did not always work together which prevented the cross referencing of data automatically. Service leaders told us they had tried to amalgamate data from two information management systems and as a result of this, some patient RTT times and waiting list details had got lost. As a consequence of this, the trust had to use a manual system to track patients and carry out harm reviews. Although the executive team had oversight of this, the senior surgical managers did not have any knowledge with regards to patients waiting or whether harm reviews had been undertaken. This meant that not all the leaders in the surgical division had a clear oversight of their current position.

Some information gathered was used for assurance, rather than quality improvement. For example, some data collected in the matrons’ audits showed compliance below target, but there were no action plans attached to this. Similarly, VTE audits carried out from October to December 2017 showed poor compliance and no action plan. Audits carried out from January to March 2018 showed even lower compliance. We were therefore not assured that data from audits was being used to improve performance.

We were told by nurses that performance and quality was discussed at ward meetings. However, most wards did not have regular meetings which included all nursing staff grades. We observed some information on performance being shared during daily huddles on some wards. Matrons’ audit results were available electronically. However, nursing staff told us they did not normally have time to look at this information.

Some information technology systems were used to monitor patient safety and improve patient care. For example, staffing levels and the monitoring of patient observations were recorded electronically. However, not all patient safety information was adequately collected using information technology. For example, since the introduction of a new patient administration system, the trust was unable to electronically report compliance to VTE risk assessments. This had been added to the trust risk register.

There were arrangements in place which ensured some data was submitted to external providers as required. For example, serious incidents and never events. However, effective arrangements
were not always in place to ensure that all information used to monitor, manage and report on quality and performance was accurate, valid, reliable or timely. For example, saving lives audit results reported to trust board were based on audits carried out by ward staff auditing their own department, and we saw long delays in the reporting of some clinical incidents. We were therefore not assured that service leaders had oversite of all quality issues.

Engagement

The service sometimes engaged with patients and staff. However, we did not see any evidence of involvement with the public and local organisations in to planning and managing appropriate services.

Results from the 2017 staff survey in surgery services showed seven areas of improvement and 15 areas which had got worse from the 2016 survey. Factors which had improved included, experiencing violence, bullying and discrimination. Areas of decline included quality of appraisals and mandatory training, fairness of reporting and confidence in reporting incidents, witnessing errors, communication and support from managers, an ability to contribute to improvements and feeling unwell due to work related stress. The service told us it was currently working on an action plan to address the issues raised. However, at the time of our inspection, the action plan had not been completed.

One of the staff survey results which had got worse from in 2016, to 2017, was the trust’s response to patient feedback. The service tried to improve the use of patient feedback through its ‘patient and carer experience strategy’. The surgical services had produced an action plan for presentation to the trust’s patient experience committee. The committee, chaired by one of the non-executive directors, were responsible for reviewing the action plan to ensure it addressed concerns raised in patient feedback.

The action plan contained three broad ambitions:

- Improve the experience of our patients and carers, from their first contact with the trust, through to their safe discharge from our care.
- Improve the information we provide to enhance communication between our staff patients and carers.
- Meet our patient’s physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique.

In addition to these three ambitions, there were also many actions to address key issues which had been identified by patients. This included, out of date surgical information on the trust’s web site, ensuring staff were always welcoming to patients and visitors, communicating with patients when there were delays, encouraging patients and carers to raise concerns and to ensure all patients were treated as individuals. All actions were due for completion by June 2018. Progress to March 2018 indicated all actions remained amber or red risk rated.
We saw ‘you said we did’ boards in clinical areas during our inspection. However, most examples displayed were positive feedback which had been given to the trust, rather than changes the service had made in response to patient feedback.

The service told us it actively encouraged feedback through the following channels:

- Talking to staff in the ward or department.
- Completing a local or national patient experience survey, including the Friends and Family Test.
- Writing or e-mailing the trust or contacting the patient advice and liaison service.
- Sharing their patient or carer experience story.
- Participating in a focus group including carers’ focus group and youth forum.
- Posting comments on social media, NHS Choices or Patient Opinion.
- Making a formal complaint.

We were not provided of any evidence that with the public and other local organisations had been involved in the planning and managing of services provided with the trust.

Learning, continuous improvement and innovation

The service did not always demonstrate its commitment to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Some of the issues we raised during our last inspection in October 2015 had not been improved. For example, staffing levels, feedback for staff from incidents and learning from serious incidents, cancelled operations and sharing of patient outcomes.

There was inconsistent investment in improvement skills for staff and service leaders. For example, not all staff had undergone appraisals and urology consultants had identified a skills gap in their department which had not been mitigated against, and most nurse leaders we spoke with had not attended any recent leadership training. However, in the surgical assessment unit (SAU) healthcare assistants had been trained in some extra skills including phlebotomy and carrying out ECG tests.

Opportunities to lean from when things went well were not evident and opportunities to learn from when things went wrong were often delayed. Complaints were not always handled in a timely way, in line with trust policy, which meant there were missed opportunities to implement change quickly.

A lead nurse for sepsis was in post. However, sepsis training had not yet been delivered to most of the nursing staff in surgical services.

Some services had improved. For example, the SAU had recently moved location to assist with the flow in the emergency department (ED). It had also begun accepting GP referrals. This made the service more accessible to patients and eased some of the pressures in the ED.

The service had commissioned an external review of its urology service in order to learn new ways of working and identify improvements.
The urology services department provided the only robotic urology service in the UK which offered advanced robotic prostate surgery. The urology team also provided state-of-the-art bladder cancer services with new diagnostic techniques. This included using cancer-specific dyes in the bladder, robotic surgery for bladder removal and the ability to robotically make new bladders and stomas. Urology services told us that their complication rates and blood loss in patients undergoing urological cancer surgery were amongst the lowest in the UK. There was an active urological cancer research programme.
Maternity

Facts and data about this service

East and North Hertfordshire NHS Trust provides maternity services to women living across much of Hertfordshire and South Bedfordshire. Inpatient maternity services are provided solely on the Lister Hospital site. Outpatient maternity services are provided on the Lister, Hertford County and QEII hospital sites. There are also four community midwifery teams based in various locations across the county, which cover North Hertfordshire, Hatfield, Welwyn and Hertford, Lee Valley and rural locations.

The maternity service is under the trust’s women and children’s division. The current leadership structure includes a divisional director, divisional chair and head of midwifery. A clinical director for obstetrics, deputy general manager, clinical governance co-ordinator, consultant midwife and matrons support the senior leadership team.

The maternity service at Lister Hospital has 75 inpatient maternity beds and provides consultant and midwife-led care for both high and low risk women. The consultant-led unit has nine ensuite delivery rooms including one with birthing pool and one bereavement suite. There is a three-bedded triage area, two dedicated obstetric theatres, a two-bedded recovery bay for post-operative women, three high-risk induction of labour rooms, and one multiple birth room. There is also a two-bedded close observation area, for women who need higher levels of care and observation than those provided on the general maternity wards.

The maternity-led unit has seven birthing rooms, four of which have birthing pools. There is a 24-bedded antenatal ward (Dacre ward), and a 27-bedded postnatal ward (Gloucester ward), which includes a six-bedded transitional care unit. Five amenity rooms are available to women who wish to pay for a private room. The maternity service also has a day assessment unit, fetal medicine service and screening services. Outpatient maternity services are provided on the hospital site, and in conjunction with community services and GP practices.

Community midwives provide care for women and their babies both during the antenatal and postnatal period. They also provide a home birth service. From December 2016 to November 2017, the reported a homebirth rate of 2.55%. This was in line with the national average of 2.3%. The community midwives are aligned to local GP practices and children’s centres.

From October 2016 to September 2017, there were 5,328 deliveries at the trust. This is a 4% decrease in the total number of births at the trust, compared with October 2015 to September 2016 data. Of these, 59% were normal (non-assisted) deliveries, which is in line with the England average (60%) and 14% were instrumental deliveries (ventouse or forceps), which is also in line with the England average (13%). Additionally, 15% were elective caesarean deliveries, which is slightly higher than the England average (12%) and 12% were emergency caesarean deliveries, which is slightly lower than the England average (15%).

A comparison of the number of births at the trust and the national totals over the most recent 12 months is shown below.
A profile of all deliveries from October 2016 to September 2017 can be viewed below.

<table>
<thead>
<tr>
<th></th>
<th>EAST AND NORTH HERTFORDSHIRE NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5,234</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>94</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother's age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>118</td>
<td>2.2%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,754</td>
<td>75.1%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,203</td>
<td>17.9%</td>
</tr>
<tr>
<td>40+</td>
<td>253</td>
<td>3.9%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>5,328</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)
Delivery trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at East and North Hertfordshire NHS Trust by quarter

![Graph showing delivery trends](image)

**SOURCE: HES - Deliveries (October 2016 - September 2017)**

Over the last two years, the number of deliveries has slightly decreased by 4% over the past five years. Quarterly figures have fluctuated between a low of 1,286, which was recorded in 2017/18 Q1 (April to June) and a high of 1,410, which was recorded in 2015/16 Q3 (October to December).

At the last comprehensive inspection in October 2015, we rated three key questions for the service as requires improvement (safe, responsive and well-led) so we re-inspected all five key questions. We previously inspected maternity jointly with the gynaecology service, so we cannot compare our new ratings with previous ratings.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We carried out an inspection of the maternity service on 20 to 22 March 2018. We did not inspect the gynaecology service. We visited clinical areas in the service including the consultant and midwife-led units, theatres, antenatal and postnatal wards, antenatal clinic, the day assessment unit and triage. We spoke with 19 women and their relatives, and 72 members of staff, including midwives, consultants, doctors, anaesthetists, senior managers, student midwives and support staff. We observed care and treatment and reviewed 19 medical care records and 21 prescription charts. We also reviewed the trust’s performance data.

### Is the service safe?

**Mandatory Training**

Medical staff compliance was variable for mandatory training, and did not meet the trust target for maternity specific training. However, we found midwifery staff had completed
mandatory and maternity specific training.

Mandatory training covered key areas such as basic life support, fire safety, infection control and prevention, and information governance. Training was provided via e-learning modules or face-to-face sessions. Staff within the maternity service understood their responsibility to complete mandatory training.

Mandatory training completion rates

The trust target for completion of mandatory training was 90%.

A breakdown of compliance for mandatory courses from April to October 2017, for medical/dental and nursing/midwifery staff in maternity is shown below.

Medical and dental staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>40</td>
<td>42</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>36</td>
<td>42</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>29</td>
<td>42</td>
<td>69.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>23</td>
<td>42</td>
<td>54.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical/dental staff was 84.4%. Of the seven mandatory training courses delivered by the trust to medical and dental staff, four met the completion rate target of 90%.

At the time of our inspection (March 2018), we found medical staff met the completion rate target for five of the seven mandatory training courses. The completion rate for fire safety had improved to 91%. However, the completion target was not met for equality, diversity and human rights, and information governance training, although we found completion rates had improved to 71% and 77% respectively.
Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>233</td>
<td>237</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>231</td>
<td>237</td>
<td>97.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>231</td>
<td>237</td>
<td>97.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>228</td>
<td>237</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>228</td>
<td>237</td>
<td>96.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>227</td>
<td>237</td>
<td>95.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>215</td>
<td>233</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>212</td>
<td>237</td>
<td>89.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing/midwifery staff was 95.4%. Of the eight mandatory training courses delivered by the trust to nursing and midwifery staff, seven met the completion rate target of 90%.

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

At the time of our inspection (March 2018), we found midwifery staff met the completion rate target for all eight mandatory training courses. The completion rate for information governance had improved to 98%.

As of March 2018, 99% of midwifery staff had completed basic adult life support training.

Effective processes were in place to ensure staff received mandatory training in safety systems, processes and practices. A practice development team had full oversight of training needs within the service and of training compliance rates. Their main role was to support staff to complete mandatory training, develop training packages in line with national recommendations, support newly qualified staff and identify any learning needs through audit, incident and complaint themes.

Training compliance for the service was reviewed monthly at the women’s speciality board meeting for obstetrics and gynaecology. Meeting minutes showed that training compliance was reviewed at the women’s speciality meeting.
Maternity specific training

Not all medical staff had completed maternity specific training, such as cardiotocography (CTG) interpretation, newborn life support and managing obstetric emergencies. All midwifery staff however, had completed training.

Midwifery and medical staff were required to complete annual emergency ‘skills and drills’ training. This was in line with national guidance (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). A multidisciplinary PROMPT style approach was used for staff to maintain their skills in obstetric emergencies, including management of the severely ill woman, shoulder dystocia, major obstetric haemorrhage, sepsis and neonatal resuscitation. PROMPT (practical obstetric multi-professional teaching) is an evidence-based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working in an emergency. As of March 2018, 100% of midwives and 71% of medical staff had completed ‘skills and drills’ training.

Midwifery and medical staff were required to complete annual CTG training. This was in line with national recommendations (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, February 2016). CTG training was provided face-to-face on the ‘skills and drills’ training day. Maternity staff were also required to complete an e-learning fetal monitoring programme. As of March 2018, 100% of midwives and 71% of medical staff had completed face-to-face CTG training. Staff were also required to attend a minimum of two CTG teaching sessions per year, which were held once a week and included individual case reviews.

Midwifery staff were also required to attend a midwives mandatory study day each year. The study day included training and updates on newborn life support, antenatal screening, infant feeding, bereavement, assessment of fetal growth and birthweight, and learning from serious incidents and complaints. As of March 2018, 96% of midwives had completed this training.

Staff undertook blood transfusion training and assessment every three years. This was in line with national recommendations (National Patient Safety Agency). As of March 2018, midwifery staff were compliant with blood transfusion training (98%).

Safeguarding

Although staff understood how to protect patients from abuse and the service worked well with other agencies to do so, not all medical staff had up-to-date safeguarding adults and children training. Midwifery staff however, exceeded the trust’s completion targets for all safeguarding training.

Safeguarding adults and children at risk was given sufficient priority within the maternity service.

There were clear systems, processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. Safeguarding policies and clinical pathways were in-date and were accessible to staff via the trust’s intranet. Pathways included clear guidance on female genital mutilation (FGM), child sexual exploitation (CSE) and substance misuse.
The trust had a named lead midwife for safeguarding and a safeguarding midwife who provided support, supervision, training and updates for staff. They attended monthly multidisciplinary team meetings with lead agencies for the purpose of reviewing safeguarding referrals and management plans, sharing good practice and policy updates.

The service also had four safeguarding champions who were based in the community, antenatal clinic, antenatal ward, and the postnatal ward. The safeguarding champions undertook regular additional training, which they then cascaded to staff within their areas.

Staff could contact the lead named midwife, safeguarding midwife, safeguarding champions, or other members of the trust safeguarding team, if they needed advice and support with any safeguarding concerns. The named lead midwife and/or safeguarding midwife also visited the wards daily, Monday to Friday, to assist with any safeguarding concerns.

The maternity safeguarding leads also produced a monthly newsletter for staff, which included key safeguarding contact information and updates in practice and guidelines. We saw examples of these during our inspection.

Midwives and medical staff were required to undertake safeguarding children level three training; this was in line with national recommendations (HM Government Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2015; RCPCH Safeguarding children and young people; roles and competences for health care staff. Intercollegiate Document, March 2014). A member of the trust’s safeguarding team, who had been nominated for the NSPCC and BASPCAN child protection trainer of the year 2018, delivered the safeguarding children training. The training programme included professional responsibilities, categories of abuse, safeguarding processes, and domestic violence. Since our previous inspection in October 2015, CSE and FGM had been incorporated in the safeguarding training programme. We saw evidence that training was multidisciplinary and included scenario-based discussion and learning from local and national serious case reviews.

Safeguarding adults level one and two training, included the Mental Capacity Act 2005, deprivation of liberty and safeguards, and the Prevent strategy, aimed at reducing the risk of radicalisation and terrorism.

**Safeguarding training completion rates**

Medical staff completion rates for safeguarding adults and children training had declined since our previous inspection (October 2015) and did not meet trust targets. This meant we were not assured all medical staff had up-to-date knowledge on how to recognise and report abuse. However, midwifery staff exceeded all completion targets for safeguarding adults and children training.

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

A breakdown of compliance for safeguarding courses from April to October 2017 for medical/dental and nursing/midwifery staff in maternity is shown below:
Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>37</td>
<td>42</td>
<td>88.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>36</td>
<td>42</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>34</td>
<td>42</td>
<td>81.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>34</td>
<td>42</td>
<td>81.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>18</td>
<td>27</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall medical staff safeguarding training completion rate was 81.5%. The trust did not meet the completion rate target for any of the safeguarding modules it delivered.

At the time of our inspection (March 2018), medical staff completion rates remained below the trust target for all safeguarding modules. This meant we were not assured all medical staff had received up-to-date training on how to recognise and report abuse. However, completion rates had improved; safeguarding adults level 1 and 2 was 85%, and safeguarding children level 3 was 74%.

Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>236</td>
<td>237</td>
<td>99.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>235</td>
<td>236</td>
<td>99.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>231</td>
<td>237</td>
<td>97.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>230</td>
<td>236</td>
<td>97.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>186</td>
<td>215</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall midwifery safeguarding training completion rate was 96.3%. The trust met the completion rate target for four of the five safeguarding modules it delivered.
At the time of our inspection (March 2018), midwifery staff were compliant with all five safeguarding modules. The completion rate for safeguarding adults level 1 and 2 was 99% and safeguarding children level 3 was 97%.

Staff we spoke with demonstrated a good understanding of their responsibilities in relation to safeguarding children and adults in vulnerable circumstances, and were confident to make safeguarding referrals.

A safeguarding alert was created on the patient’s hospital electronic record, which alerted staff to any safeguarding concerns. Community and inpatient maternity services liaised to identify and support the management of safeguarding risks.

The safeguarding team maintained a secure database of all women with safeguarding concerns under their care, which midwifery staff could access. Information on the database was updated as required. The database included details of safeguarding referrals made, management plans and minutes of case conference meetings. We observed this during our inspection.

Maternity staff liaised with other professionals and agencies, such as health visitors, social workers, the police, independent domestic violence advisors, and the community perinatal mental health team, as needed.

All staff told us there were good links between maternity services and the perinatal mental health team. Staff told us they received a timely response if they referred a patient for assessment or support.

The trust had up-to-date guidance on FGM, which was in line with national recommendations. Clinical pathways were in place for the mandatory reporting and safeguarding of women with known, suspected and/or risk of FGM, which staff could access via the trust intranet. Staff we spoke with were aware of their mandatory duty to report all cases of FGM in children and young people under the age of 18 and children and young people at risk of FGM being performed.

A consultant obstetrician was the FGM champion for the trust. Weekly clinic slots were available for women who had undergone FGM, if needed. We were told the service generally had one to two FGM referrals per month.

The trust had an up-to-date abduction policy, and measures and controls were in place to minimise the risk of a baby being abducted from the unit. The trust had not simulated the abduction of a baby from the maternity unit. We were told this was scheduled to take place before the end of April 2018. A patient and their partner would be asked to assist in the simulation exercise to make it as real as possible and maximise the learning.

A baby identity tagging system was in use within the service. Every baby had an identity tag applied to each ankle shortly after birth, which included the baby’s name, date of birth and the mother’s name. The identity tags were checked on admission to the postnatal ward following transfer from the consultant-led unit, midwife-led unit or theatre and on a daily basis, as part of the routine postnatal check. Staff told us if they found a baby with both tags missing, they would report it via the electronic reporting system and all babies in the unit would be checked to confirm their identity. We found no such incidents had been reported from January to December 2017.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment, and the premises clean. They used control measures to prevent the spread of infection.

All areas of the maternity service we visited were visibly clean and tidy during our inspection. Data provided by the trust and women we spoke with corroborated this.

Monthly cleaning audits were carried out within the service. The results of cleaning audits carried out between October 2017 and March 2018, showed the average compliance score was 93% for the consultant-led unit, 99% for the midwife-led unit (MLU), and 97% for the antenatal and postnatal wards.

There was a service level agreement in place between the trust and an external provider who cleaned patient and public areas, in accordance with daily and weekly cleaning schedules. We saw completed cleaning checklists in areas we visited.

Midwifery and support staff were responsible for cleaning the equipment. We saw that “I am clean” stickers” were used to show when equipment was clean and ready to use. We observed equipment was cleaned daily, with the exception of three breast pumps on the postnatal ward.

Reliable systems were in place to prevent and protect people from a healthcare-associated infection. We observed clinical staff adhere to the trust’s ‘arms bare below the elbow’ policy to enable effective hand washing and reduce the risk of spreading infections. There was access to hand washing facilities, hand sanitising gel, and a supply of personal protective equipment (PPE), which included gloves and aprons, in all areas.

Staff washed their hands between patient contact, in accordance with national guidance (NICE Infection prevention and control: QS61, quality statement 3, April 2014). Women we spoke with corroborated this. From October 2017 to March 2018, the monthly audit results for all inpatient areas showed hand hygiene compliance was generally 100%. The only exception to this was in October 2017, when hand hygiene compliance in the midwifery-led unit was 90%.

As of March 2018, 98% of midwifery and 91% of medical staff had completed infection prevention and control training.

Women were offered screening for infectious diseases, such as hepatitis B and syphilis. Women were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, updated January 2017). The antenatal records we reviewed confirmed this.

The service monitored postnatal readmission rates for infection. From January 2017 to January 2018, 17 women were readmitted within 42 days of delivery for puerperal infection. In relation to the total number of deliveries for this period, this equated to a readmission rate of 0.3% for maternal infection.

From April 2016 and March 2018, zero cases of hospital acquired MRSA (antibiotic resistant bacteria) and Clostridium difficile (C.difficile) (bacteria that can infect the bowel and cause diarrhoea) were reported by the service.

Side rooms were available on the antenatal and postnatal wards, which could be used to admit women with a known or suspected infection. Staff we spoke with could describe what they would do if a patient required isolation due to infection.
Environment and equipment

Sharps containers did not have temporary closures in place, which was not in line with national recommendations. However, the service had suitable premises and sufficient equipment and generally looked after them well. Processes were in place to ensure emergency equipment was checked daily.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Sharps boxes were clean, dated and were not overfilled. However, none of the sharps boxes we observed (14 in total) had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries. The service did not report any incidents of needle-stick injury through the national reporting and learning system in 2017.

Adult resuscitation equipment was available on the consultant-led unit (CLU), midwifery-led unit (MLU), wards, theatres and outpatient areas. Resuscitation trolleys were checked daily to ensure the electrical equipment was in working order and tamper seals were in place. Two registered members of staff checked all equipment and medicines stored in each resuscitation trolley weekly. We reviewed the daily and weekly checklists for the CLU, MLU and postnatal ward (which shared a resuscitation trolley with the antenatal ward) from 1 to 20 March 2018 and all were complete.

Resuscitaires (used to support newborn babies who may need resuscitation after delivery) were available on all maternity inpatient areas and obstetric theatres. We reviewed the checklists for resuscitaires situated on the CLU, MLU and postnatal ward from 1 to 20 March 2018 and found all were complete, with the exception of two omissions. We checked a sample of consumable items from the resuscitaires for expiration dates, including syringes, airways and blood bottles; all were in-date (17 items).

The CLU had an emergency trolley, which contained equipment for managing obstetric emergencies such as postpartum haemorrhage and pre/eclampsia. We reviewed the daily checklists from 1 to 20 March 2018 and all were completed.

The postnatal ward stored equipment for managing haemorrhage in a large box. However, staff told us that they struggled to lift it, due to its size and weight. We also found the trust’s guideline for the management of postpartum haemorrhage stored in the box was an out-of-date version and had expired in December 2014. This guideline had been updated and a current version was available on the trust’s intranet.

Electrical equipment was regularly serviced and safety tested, to ensure it was safe for patient use. We reviewed 54 items of equipment from the CLU, MLU, antenatal and postnatal wards, antenatal clinic and triage and found all equipment had been serviced within the date indicated, with the exception of one portable light.

Access to the consultant-led unit (CLU), midwife-led unit (MLU) and wards was by means of swipe card or an intercom buzzer system to gain entry to the wards. There were also security cameras at the entrances to clinical areas. This meant staff could identify visitors and ensure women and their babies were kept safe.

The CLU, obstetric theatres, triage and neonatal unit were situated on the ground floor, which enabled timely transfer when required. The MLU and antenatal and postnatal wards were situated on the first floor; two patient lifts were available to transfer women and/or babies when required.
The failure of both lifts was listed on the service’s risk register. We saw an action plan and controls were in place to address this risk.

The emergency buzzer system in for the CLU and MLU could not be heard in the triage unit, and recovery, theatres and close-observation areas within the CLU. This meant there was a risk that women and/or babies may be harmed because of a delay in staff attending in an emergency. This was listed on the risk register and we saw that controls were in place to minimise this risk.

Estimates for a new emergency buzzer system had been submitted to the head of midwifery. Until a new system was installed the obstetric team and CLU coordinator carried devices, which alerted them when any emergency buzzers were activated in these areas.

Flooring was non-slip and in good condition in all areas we visited.

We observed fire exits were kept clear and free from obstruction.

The CLU had a fetal blood gas analyser. This was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

A laboratory facility for blood and blood products was available at the hospital.

From January to December 2017, the service reported 14 incidents regarding equipment through the national reporting and learning system. This equates to approximately 1.4% of total incidents reported by the service. All the incidents were graded as having caused ‘no harm’. The majority of equipment incidents reported were because of a lack of or faulty cardiotocography (CTG) machines in the antenatal ward, which caused delays in patient care. At the time of our inspection (March 2018), the service had recently purchased three additional CTG monitors for the antenatal ward. This meant they had sufficient monitors for the ward’s activity. A CTG machine is used to record both the fetal heart and uterine contractions during pregnancy and labour. Its purpose is to monitor fetal wellbeing and allow early detection of fetal distress.

We were told not all community midwives had access to transcutaneous bilirubinometers (a non-invasive device used to measure the serum bilirubin level of babies with suspected jaundice). Staff told us that if they suspected jaundice but did not have access to a transcutaneous bilirubinometer, they would refer the baby to the postnatal ward for review.

The CLU and MLU met the Department of Health’s recommendation that all birthing rooms should include en-suite facilities (DH Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013).

Assessing and responding to patient risk

Not all risks to patients were consistently monitored and completed. We found swab and needle counts, carbon monoxide testing and peer reviews of cardiotocography traces were not always carried out in line with trust and national guidance. However, the service planned for emergencies and staff understood their roles if one should occur.

We were not assured that swabs, instruments and needles used for vaginal birth and perineal suturing, were always counted for completeness by two members of staff, as per national recommendations (NPSA Reducing the risk of retained swabs after vaginal birth and perineal suturing: 1229, 26 May 2010). Swab count audits carried out in 2017 showed variable compliance. For example, in November 2017 the service audited compliance with swab and needle counts
from births that occurred in the consultant-led unit (CLU), midwife-led unit (MLU) or at home between May and July 2017. The audit found that 72% of records had two signatures to verify the swab count for vaginal delivery. Furthermore, only 68% had two signatures to verify the swab and needle count pre- and post-suturing. We reviewed eight maternity records, and found that one did not have two signatures to evidence that the swab count and needle count had been verified. The service had reported one never event in April 2017, where a suture needle was retained by a patient following perineal repair.

We were not assured all women were offered carbon monoxide testing in accordance with national recommendations (NHS England Saving Babies’ Lives, 2016). In September 2017, a smoking service review found 77% of women had carbon monoxide testing at booking and 50% of women who smoked at booking had testing in their third trimester. We found carbon monoxide testing was not recorded in four of the eight handheld pregnancy records we reviewed. We raised this with senior staff at the time of our inspection and were told action had been taken to improve compliance, which included the purchase of additional carbon monoxide monitors and further smoking cessation training.

A buddy system was in place for review of cardiotocography (CTG) interpretation, with guidance for escalation if concerns were raised. This was in line with national recommendations (NHS England Saving Babies’ Lives, 2016). The service used the ‘fresh eyes’ approach to CTG interpretation and classification. This meant a second midwife was required to review the CTG recording hourly during labour, to ensure it had been interpreted correctly and appropriate actions were taken when indicated. In November 2017, compliance with CTG peer reviews was included in the trust’s care of women in labour audit. The audit found 86% of records reviewed had hourly ‘fresh eyes’ reviews documented, versus 84% compliance in 2016. Furthermore, 93% of records showed that appropriate action was taken when the CTG was categorised as non-reassuring or abnormal. However, this result was worse than 2016, when 100% compliance was found. Although the service had met the trust target, which was 75%, the target was low and was not in the spirit of ensuring that all CTGs were seen with a ‘fresh pair of eyes.’ In addition, the number of CTGs checked had reduced. From the maternity records we reviewed, we found CTG peer reviews were generally carried out hourly and CTG traces were escalated appropriately, where indicated.

In November 2017, the care of women in labour audit showed there was poor compliance with the use of SBAR (situation, background, assessment and recommendation). The audit showed 64% of antenatal transfers of care used the SBAR handover tool, of which only 53% were fully completed. However, the records we reviewed during our inspection showed that SBAR was used as a handover tool. SBAR is a structured method for communicating critical information that requires immediate attention and action, contributing to effective escalation and increased patient safety.

The service generally completed venous thromboembolism (VTE) risk assessments (used to determine a patient’s risk of developing a blood clot), in line with national recommendations (RCOG Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline No.37a, April 2015). We reviewed eight VTE risk assessments and found they all had the initial antenatal and postnatal VTE assessment completed. However, three of the records did not include a VTE admission assessment.

The maternity service used an adapted version of the World Health Organisation (WHO) surgical safety checklist. This was in accordance with national recommendations (NPSA Patient Safety
Alert: WHO Surgical Safety Checklist, January 2009). The checklist was used for women having a caesarean section or other obstetric surgical procedure, such as instrumental delivery. The service audited the completion of WHO surgical safety checklists in March and April 2017; 70 sets of notes were reviewed. The audit showed compliance with completion was 93%. This was lower (worse) than the result reported in 2016, which was 96%. We reviewed four WHO checklists during our inspection and found they were completed. We observed that staff adhered to the WHO checklist in theatre.

The maternity service used a modified obstetric early warning score (MEOWS), designed to allow early recognition and deterioration in pregnant and postnatal women by monitoring physical parameters such as blood pressure, heart rate and temperature. An audit of sepsis care in February 2018, showed 100% compliance with the completion of MEOWS. We reviewed eight MEOWS charts during our inspection and found they were completed and escalated, where indicated.

Since our previous inspection in October 2015, the service had introduced the newborn early warning trigger and track (NEWTT), designed to identify babies at risk of clinical deterioration following birth and initiate prompt investigation and intervention. We reviewed four NEWTT charts and found they were completed, in line with trust guidance.

Full risk assessments of women were carried out at the initial antenatal booking appointment. These included medical, social and mental health assessments. Other assessments included tobacco and drug use, and family and obstetric history. The findings of these risk assessments were used to help women choose their preferred place of birth and plan future care provision. Women who were unsuitable for midwifery-led care were referred to the obstetrics team for review and management. This was confirmed in the risk assessments we reviewed.

Clinical staff continued to complete risk assessments throughout the antenatal, intrapartum and postnatal period, as needed. Risk assessments were carried out for pre-eclampsia and gestational diabetes, in line with national guidance (NICE Antenatal care: QS22, last updated April 2016). Women who were at high-risk of gestational diabetes were for example, referred for glucose tolerance testing.

We saw evidence that women were routinely asked about their baby’s movements at each antenatal contact. Written information regarding this was also given to the women by 24 weeks gestation. This was in line with national guidance (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, 2016). Women were advised to contact the day assessment unit (DAU) or maternity triage unit if they had any concerns about their baby’s movements. We heard midwives routinely ask women about their baby’s movements during our inspection.

The maternity service used customised fetal growth charts to help identify babies who were not growing as expected. We saw that symphysis-fundal height measurement was routinely performed from 26 to 28 weeks gestation. This was in line with national guidance (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, 2016). Women who measured below the 10th centile or showed slow or static growth were referred to the DAU or triage for review and further investigations, for example, a growth scan.

There was a designated three-bedded maternity triage unit, situated opposite the consultant-led unit (CLU), which provided 24-hour assessment, review and ongoing care planning for pregnant women from 20 weeks gestation. Women could telephone for advice or present to the triage unit if they had concerns or health issues such as pain reduced fetal movements or vaginal bleeding.
All telephone calls to the maternity triage unit were documented. If a woman called the unit three times or more in a 24-hour period they were invited to attend for review regardless of concerns and/or symptoms reported, as the service recognised that frequent calls could be as a result of domestic violence or mental health concerns.

Women who reported no fetal movements, or presented with imminent delivery, symptoms of severe pre-eclampsia and/or significant vaginal bleeding, were admitted directly to the CLU. The triage unit had birthing equipment available to facilitate the safe delivery of a baby, if a woman presented in advanced labour and could not be transferred to the CLU.

There was a pathway for the management of sepsis. Staff we spoke with were able to describe what actions should be taken when a patient was admitted with suspected or known sepsis and what treatment should be initiated, in line with national guidance. We reviewed the maternity records of one patient who was being treated for sepsis. We found there was prompt identification, escalation and implementation of the sepsis care bundle.

The CLU had a two-bedded close observation area for women who needed higher levels of care and observation than provided on a general maternity ward. The critical outreach team were available to support staff with the care and management of high dependency women, as needed. Critically ill women were transferred to the hospital’s intensive treatment unit (ITU). From March 2017 to February 2018, six women were admitted to ITU. This equates to approximately 0.1% of women who delivered at the hospital.

A local agreement with the ambulance service was in place for attendance at emergencies, such as babies born unexpectedly at home.

Women who were booked for elective caesarean section attended a pre-operative assessment clinic, where risk assessments were carried out, including blood tests and anaesthetic review.

Staff told us if they were concerned about a patient’s mental health, they would refer to the perinatal mental health team, psychiatric liaison team or crisis team.

Midwives on the postnatal ward carried out daily assessment and review of each patient, which included their mental health and emotional wellbeing. The records we reviewed corroborated this.

We saw evidence that impromptu emergency scenarios were held to maintain and improve the skills needed in the event of an obstetric emergency. Examples included the management of shoulder dystocia, postpartum haemorrhage and neonatal resuscitation. The evaluation records showed what went well, what could have gone better, and learning points and actions.

**Midwifery and nurse staffing**

**Staffing levels were often lower than planned and the trust relied on bank and agency staff. However, staffing levels were regularly reviewed and staff were redeployed within the unit when needed, to keep patients safe from avoidable harm and to provide the right care and treatment. Women generally received one-to-one care in labour.**

The trust has reported their staffing numbers below for year of 2016/17 and year to date, which covers April to October 2017.
<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Maternity</td>
<td>199</td>
<td>214</td>
</tr>
</tbody>
</table>

This meant staffing in the maternity service was lower (worse) than planned.
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**

From December 2016 to October 2017, the trust reported a vacancy rate of 23.1%. This was significantly higher than the trust target of 6%. We were told the service had recently appointed two band six and 19 band five midwives, which meant there were three midwifery vacancies at the time of our inspection. Four midwives were starting in April, four in June and the remaining 13 were due to commence in September, once they had qualified.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From December 2016 to October 2017, the trust reported a turnover rate of 25% in maternity. This was significantly above the trust target of 12.7%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From December 2016 to October 2017, the trust reported a sickness rate of 4.6% in maternity, which was higher than the trust target of 3.3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

The service relied on bank and agency staff to meet planned staffing numbers. On the second day of our inspection (21 March 2018), we observed that out of a total of 42 planned registered staff shifts for that day, six had been filled by agency staff and 11 had been filled by bank staff. This equated to 40% of shifts filled by temporary staff. From December 2016 to October 2017, the trust reported approximately 11% of shifts were filled by agency staff and 37% by bank staff.

We spoke with bank and agency staff who told us they had received a good orientation and induction before they commenced clinical duties. We were told the majority of bank staff had either retired from or held substantive (permanent) midwifery posts within the trust. Agency staff we spoke with told us they regularly worked at the hospital.

The inadequate numbers of midwives on some shifts was listed on the risk register in November.
2014. We saw mitigating actions were in place such as the use of specialist midwives, and bank and agency staff when needed. The service was also actively recruiting for midwives to minimise this risk. A recruitment open day was planned for May 2018.

An escalation plan was in place to address staffing issues. This included the redeployment of midwives from other areas and/or specialist roles, to support the unit when needed. A senior member of staff was on-call out-of-hours, seven days a week, to support effective working and patient flow within the unit.

Staffing levels, skill mix and patient acuity were monitored daily. The nominated ward manager checked staffing levels and patient acuity three times a day. Staff could also contact them via the bleep system for assistance with staffing issues when needed.

The service used a traffic light system to rate and flag staffing issues. Green rating showed staffing numbers were safe. Amber rating indicated staffing numbers were not as expected and minor adjustments were needed to meet workload and acuity, or staffing numbers were as expected but given workload and acuity, additional staff were needed. Red rating indicated staffing numbers were inadequate to cope with workload and patient acuity. The ward manager reported the RAG rating for the unit to the trust’s daily safer staffing meeting. We observed this meeting during our inspection and saw action was taken to mitigate staffing levels. For example, an urgent text message was sent to bank staff asking if anyone was able to work any additional hours. Staff were also redeployed between the maternity wards to ensure patient acuity needs were met.

The maternity safer staffing return for January and February 2018 showed 75% of shifts were green rated, 25% were amber rated and 0.1% were red rated. However, mitigating actions such as the redeployment of staff were not always recorded on the safer staffing return. This meant we could not verify that action to address staffing shortages and ensure patients’ needs were met was consistently taken. For example, there were no mitigating actions recorded on the safer staffing return for the red rated shift.

We found actual staffing levels were often lower than planned. The maternity safer staffing return for January and February 2018 showed that 23% of shifts did not have the planned number of registered staff. The majority of unfilled shifts were for early (43%) and/or late (48%) shifts. Only 9% of night shifts did not have the planned number of registered staff.

Staff we spoke with told us that it was common to be short of midwives on shift and they were often unable to take statutory breaks. During the handover we attended, we heard that the majority of staff who had worked the night shift had not had a break. This was similar to what we found at our last inspection (October 2015), when we reported staff regularly missed their breaks because they were too busy to take them. Staff told us they were remunerated when they were unable to take their break.

Staffing incidents were reported via the electronic reporting system. From January to December 2017, the maternity service reported 28 incidents related to lack of suitably trained and/or skilled staff through the national reporting and learning system (NRLS). This equates to approximately 3% of total incidents reported by the service. All incidents were graded as having caused ‘no harm’. The incidents reported through the NRLS did not include immediate actions taken to minimise the risk to patients. Therefore, we were unable to verify that actions were taken.

The service did not monitor staffing red flags (NICE Safe midwifery staffing for maternity settings:
Staffing red flag events are signs that there may not be enough midwives available.

The service used the Birthrate Plus midwifery workforce tool to calculate the level of midwifery staff needed based on the trust's activity, case mix and demographics. The head of midwifery undertook this review quarterly. Birthrate Plus is recommended by the Department of Health, endorsed by the Royal College of Midwives, and is incorporated within the standards issued by the NHS Litigation Authority.

The service last commissioned Birthrate Plus to carry out a formal workforce review in September 2014. We were told the director of nursing was keen for this to be repeated, however this had not been confirmed at the time of our inspection.

**Midwife to birth ratio**

From April to December 2017, the trust’s quarterly staffing review calculated a ratio of one midwife to 28.5 births was needed. The trust’s target was one midwife to 29 births.

As of June 2017, the trust had a ratio of one midwife to every 34.5 women, which was higher (worse) than the trust target and nationally recommended workforce ratio of one midwife to 28 births.

(Source: Electronic Staff Records – EST Data Warehouse)

From March 2017 to January 2018, the midwife to birth ratio was between 1:30 and 1:31. This was higher (worse) than the trust target. However, we saw that in February 2018, the midwife to birth ratio was 1:29.

Women generally received one-to-one care in established labour. This was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). From March 2017 to February 2018, the average compliance rate was 98.5%. The seven postnatal women we spoke with confirmed they had all received one-to-one care in labour. Furthermore, results from the national maternity safety thermometer showed the proportion of women who felt they were left alone at a time that worried them was in line with the England average from April 2017 to March 2018.

Midwifery handover took place at the change of each shift. Handover included an overview of all women and/or their babies, safeguarding concerns and the allocation of workloads. A detailed bedside handover of each patient took place between midwives. Handover also included 'message of the week', where information regarding recent incidents for example, were shared with staff.

A senior midwife coordinated the activity for each shift on the consultant-led unit. The coordinator was mostly supernumerary, which enabled them to have oversight of the ward activity and support staff as needed. This was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

The service employed one consultant midwife, which was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

Student midwives were supernumerary and not included in the midwife-staffing establishment.
Every student was assigned a midwife to work with on shift.

Ward managers and some specialist midwives were supernumerary, which meant they were able to support ward staff clinically when needed.

Staffing levels were displayed publically in all clinical areas for midwifery/nursing staff and health care support workers.

**Medical staffing**

Medical staffing levels within the service were sufficient to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. Staffing skill mix levels were generally in line with the England average.

We were assured there was sufficient on-site consultant obstetric cover. The service provided 122 hours of consultant obstetric cover on the consultant-led unit (CLU) per week.

On-call arrangements were in place and worked well. Staff we spoke with did not have any concerns about contacting the on-call team when needed.

An obstetric consultant provided on-site cover 24-hours a day, Monday to Thursday. On Friday, consultant on-site cover was from 8.30am to 8.30pm and on the weekends, on-site cover was from 8.30am to 3.30pm. Out of these hours, a consultant was on-call from home.

Obstetric anaesthetic cover was available 24-hours a day, seven days a week. Consultants and middle grade anaesthetists provided this. Separate anaesthetists were rostered to cover the elective caesarean section list and CLU. On the weekends and out-of-hours, one resident anaesthetist was on-call for the CLU and a second was available to assist when needed. In addition, a first and second consultant anaesthetist was on-call from home.

There was up to four consultant-led ward rounds per day, where activity was discussed and patients were reviewed. Patients were prioritised according to their risk. At weekends and bank holidays, this was held once a day. A consultant-led ward round was also held in the antenatal ward each day. They would also review postnatal patients, as needed.

The trust’s medical staffing numbers for the financial year 2016/17 and year-to-date, which covers April to October 2017, are shown below.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
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<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Maternity</td>
<td>43</td>
<td>46</td>
</tr>
</tbody>
</table>

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

This meant medical staffing numbers were slightly below planned numbers.
Vacancy rates
From December 2016 to October 2017, the trust reported a vacancy rate of 6.4% in maternity for medical staffing, which was in line with the trust target of 6%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
The senior management team told us they had appointed four consultants and 15 middle grade doctors. This meant there were no vacancies at the time of our inspection (March 2018).

Turnover rates
From December 2016 to October 2017, the trust reported a turnover rate of 12.3% in maternity, which was in line with the trust target of 12.75%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From December 2016 to October 2017, the trust reported a sickness rate of 2.1% in maternity for medical staffing, which was better than the trust target of 3.3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets within a standard template. The data the trust has provided does not include details on the number of shifts filled by substantive staff in total shift figures, which means we cannot provide an accurate bank and locum usage figure.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix
In October 2017, the proportion of consultant staff reported to be working at the trust and the proportion of junior (foundation year 1-2) staff were higher (better) than the England averages.
Staffing skill mix for the 35.8 whole time equivalent staff working in maternity at East and North Hertfordshire NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>40%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</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

Patient handheld records did not always contain a complete set of antenatal screening results, which was not in line with national guidance. Otherwise, we found staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and were generally available to all staff providing care.

The maternity service used the standardised maternity notes developed by the perinatal institute for pregnancy, labour and birth, and postnatal care. Some paper records, such as prescription and observation charts were also in use.

Women carried their own handheld pregnancy records, which they were advised to bring to each antenatal appointment and any occasion when they attended the hospital.

In April 2017, an audit of antenatal care against national guidance (NICE Antenatal care for uncomplicated pregnancies: CG62, last updated January 2017; NICE Antenatal care: QS22, last updated April 2016) found 73% of handheld records contained a complete record of the minimum set of antenatal screening test results. This was below the trust target of 75% compliance. During our inspection, we found seven out of eight handheld records we reviewed included a complete record of antenatal screening results and ultrasound findings. This would indicate that compliance had improved.

In December 2017, an audit to establish whether patient records met trust and national standards showed overall compliance was 96%. The audit found, for example, that 100% of entries were
legible, timed and did not include jargon or offensive statements, and 95% of entries were dated and relevant information was recorded.

We reviewed 10 sets of maternity records and found these were generally completed in line with national standards (NMC The Code: Professional standards and behaviour for nurses and midwives, 2015). Records were contemporaneous, legible, dated and signed.

Regular clinical assessment was evident in the maternity records we reviewed. Clinical assessments, such as blood pressure, urine analysis and abdominal palpation were documented. Relevant previous and current clinical information was completed and risk assessments were evident, with details of actions taken where appropriate.

Discharge summaries were sent to health visitors and GPs. The summary included information about the woman’s pregnancy, birth and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed.

The personal child health record (also known as the ‘red book’) was given to mothers on discharge. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

We found records were stored securely. We did not observe any unattended records during our inspection. We found computer terminals were locked when not in use.

Documentation incidents were reported via the electronic reporting system. From January to December 2017, the maternity service reported 45 documentation related incidents through the national reporting and learning system. This equates to approximately 4.5% of total incidents reported by the service. Common themes were the misfiling of patient information, breach of patient confidentiality, incorrect information recorded, unavailability of maternity records and poor record keeping. All incidents were graded as having caused ‘no harm’.

The inpatient wards used ‘patient safety at a glance’ (PSAG) white boards to display women’s names, their location and key information. Hospital wards use PSAG boards to display important information such as risks, progress of labour, mode of delivery, infant feeding method, discharge information and safeguarding concerns. The PSAG boards were located in staff areas, out of public sight from women and visitors. This meant that women’s personal information was protected.

Medicines

We were not assured effective governance arrangements were in place to ensure controlled medicines and storage temperatures were checked daily, and that out-of-range temperatures were acted upon, when indicated. However, the service prescribed, gave and recorded medicines well.

We found variable compliance with the monitoring and safe storage of medicines. Staff were required to check the physical stock of controlled drugs (medicines subject to additional security measures) against the stock level recorded in the controlled drug register once daily. This was to minimise the risk of them being misappropriated. We reviewed the controlled drug registers for the midwife-led unit (MLU) and postnatal ward from 1 January to 20 March 2018, and found 13 occasions when they had not been checked. We saw three consecutive days of omissions in the
MLU controlled drug register. We were told this was because the medicine keys went missing over a weekend, and the locks were replaced on the Monday. No discrepancy in stock levels was found. However, the registers for the consultant-led unit (CLU) and antenatal ward were reconciled daily.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. We reviewed the fridge temperature checklists for the CLU, MLU, antenatal ward and antenatal clinic from 1 January to 20 March 2018 and found 21 omissions. We saw current fridge temperatures were within the recommended range. However, the checklists we reviewed for the CLU showed the maximum fridge temperature was consistently exceeded in January and February 2018, but there was no evidence that action was taken to address this. On one occasion in January 2018, the maximum fridge temperature recorded was 21.2°C; the recommended range is between two and eight degrees centigrade.

We were told that ambient room temperatures were not monitored. This meant we were unable to determine how the service ensured medicines were effective and safe for patient use. There is no national requirement to monitor the temperature, but it is considered best practice.

We found two out-of-date medicines in the day assessment unit, which had expired in December 2017 and February 2018. All other medicines we checked were in-date (69 in total).

Intravenous fluids (fluid given via a vein) were stored appropriately in locked cupboards. We reviewed 24 bags of fluid and all were in-date.

Medicines were securely stored in all clinical areas we visited. Controlled drugs were stored correctly within wall mounted locked cupboards. Controlled medicine destruction kits were available for the disposal of unused or partially used controlled medicines.

We reviewed 20 prescription charts and found they were all signed, legible, patient allergies were clearly documented and medicines were given as prescribed. Patients’ weight was recorded in all but one chart. This is important because the correct dose of some medicines is determined by the patient’s weight.

Prescription charts were designed to prompt the medical team to review courses of antibiotics at appropriate intervals, usually 48 hours for intravenous antibiotics and five days for oral antibiotics.

Medicine incidents were reported via the electronic reporting system. From January to December 2017, the maternity service reported 47 medication incidents through the national reporting and learning system. This equates to approximately 5% of total incidents reported by the service. All incidents were graded as having caused ‘no harm’. Common themes included missed and/or delayed administration, wrong dose, wrong frequency and/or wrong route, and prescription errors. We reviewed the investigation report for one medicine incident and saw comprehensive investigation, immediate and additional actions taken and the duty of candour was applied.

**Incidents**

Perinatal mortality and morbidity meetings lacked detail, and there was little evidence of the learning from them. However, the service generally managed patient safety incidents well. Staff recognised and reported incidents appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When
things went wrong, staff apologised and gave patients honest information and suitable support.

Perinatal mortality and morbidity meetings were held monthly. However, these were not formally minuted and did not have attendees listed. We were told the meetings were multidisciplinary and were attended by members of the obstetric, neonatal and midwifery team, but without a list of attendees we were unable to verify this. The six sets of meeting minutes we reviewed showed an outline of each case was presented, followed by a discussion, where any learning from each case was identified. However, we did not see evidence that any actions were then taken to minimise the risk of recurrence and/or improve patient outcomes. Nor how any learning was to be shared within the service.

The service did however, use a national perinatal mortality review tool to review all perinatal deaths over 22 week’s gestation. This was in line with national recommendations (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) 

Perinatal Mortality Review Tool, February 2018). The software tool was designed to support standardised, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, so that care can be improved and avoidable deaths prevented. The service introduced the MBRRACE-UK perinatal mortality review tool in February 2018. Prior to this, they used the standardised clinical outcome review (SCOR), which was developed by the Perinatal Institute. We reviewed seven sets of SCOR action plans and saw comprehensive perinatal mortality reviews were carried out. However, it was not evident that all actions identified had been completed.

The maternity service reported all premature births between 22+0 and 23+6 weeks gestational age who did not survive the neonatal period, in line with national recommendations (MBRRACE-UK, 2015).

The hospital used an electronic system for reporting incidents. Staff we spoke with said they were encouraged to report incidents, and felt confident to do so. We observed the PSAG white board in the consultant-led unit included a prompt to remind staff to submit an electronic incident report, when indicated.

Incidents were reviewed daily, Monday to Friday, and where necessary investigations were initiated to identify any themes and actions needed to minimise recurrence. Any potential serious incidents were escalated to the serious incident panel for review.

We observed that staff received feedback on incidents in a variety of ways, such as emails, noticeboards, message of the week, and governance meetings. Staff we spoke with corroborated this.

**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 January to December 2017, the trust reported one incident, which was classified as a never event for maternity. The never event was classified as a maternity/obstetric incident meeting
serious incident (SI) criteria: mother only, and was in relation to a retained suture needle. The never event occurred in April 2017.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents in maternity, which met the reporting criteria set by NHS England from January to December 2017.

These were:

- Maternity/Obstetric incident meeting SI criteria: mother only, with one (33% of total incidents)
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant), with two (66% of total incidents)

(Source: Strategic Executive Information System (STEIS))

We reviewed the investigation reports for the never event and two most recent serious incidents and found comprehensive investigation, recommendations and actions taken to minimise the risk of recurrence. For example, in response to the never event, the trust introduced sticky pads for use when staff undertook suturing. These were already used in theatre, and meant needles that were not in use could be safely stored. This reduced the likelihood of a needle being mistakably retained by a patient and any needle stick injury occurring. Learning from this incident was shared via email, message of the week, the clinical governance monthly newsletter and the clinical governance rolling half day audit meeting. All staff we spoke with could describe the never event and the lessons learned. However, an audit of 79 records for deliveries that occurred from May to July 2017, showed only 68% of records had documented evidence that two members of staff had verified the needle count pre- and post-suturing. Therefore, we were not assured learning from the never event was embedded in practice.

From January to December 2017, there were 1,000 incidents reported for maternity through the national reporting and learning system. Incidents were graded from no to low harm, or moderate to severe harm or death. The majority of incidents were graded as having caused no or low harm (71% and 18% respectively). Of the remaining incidents, 10% were graded as having caused moderate harm, and 0.3% as having caused severe harm or death.

(Source: National Reporting and Learning System (NRLS))

Incidents were generally reviewed in a timely manner. As of 22 March 2018, the maternity service had 55 incidents awaiting closure, two of which dated back to October 2017. We were told these incidents had been reviewed but had not been closed on the electronic reporting system. Of the remaining incidents, two dated back to January 2018, 16 dated back to February 2018 and the rest had been submitted that month (March 2018). This was an improvement from our previous inspection when we found incidents were not always reviewed promptly.

When things went wrong, staff apologised and gave patients honest information and support.

The trust had a duty of candour policy, which staff could access via the trust intranet. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were aware of the importance of being open and honest with women and those close to them when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened.

We saw evidence that duty of candour regulations were followed in the incident reports we reviewed. Women and families were involved in the investigation process and informed of the outcomes. The investigation report was shared with the woman, her family and/or representative(s) on completion.

Safety thermometer

The service used safety-monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service. The trust’s maternity safety performance was in line with the England average.

The maternity service used the national maternity safety thermometer, which was designed to support improvements in patient care and experience. It recorded harm associated with maternity, such as perineal trauma, infection and women’s psychological perception of safety, and the proportion of mothers who have experienced ‘harm free’ care.

From April 2017 to March 2018, the trust’s average combined harm free score was 76%, which was in line with the England average of 74%. On average, the trust scored better or in line with the England average in all of the nine indicators measured, including infection, perineal trauma, women’s perception of safety, harm free physical care and babies with an Apgar score less than seven at five minutes. The Apgar score is an evaluation of the condition of a newborn based on a rating of zero, one or two for each of the five characteristics of colour, heart rate, response to stimulation, muscle tone and respiration, with 10 being the optimum score.

Staff told us that action was taken in response to the safety thermometer results, as needed. For example, women that reported they ‘were left alone at a time that worried them’, or their ‘concerns about safety during labour and birth were not taken seriously’, were offered the birth afterthoughts service.

The trust’s website included a direct link to the NHS maternity safety thermometer website.

Is the service effective?

Evidence-based care and treatment

The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment. Local and national audits were completed and actions were taken to improve care and treatment provision when indicated.

There was an effective system in place to ensure policies and clinical pathways reflected national guidance. These were reviewed at least every three years, or when national guidance was published. Staff were informed of updated guidelines via email, newsletters and staff noticeboards.
At the time of our inspection, the service was working collaboratively with neighbouring trusts to develop network guidelines, which would be standardised across the local maternity system, where appropriate.

We observed all maternity guidelines, policies and clinical pathways were within review date. We reviewed five guidelines in depth and found they were in line with, and referenced national guidance. However, we did find some patient information leaflets, which were available from clinical areas and wards, had passed their review date. Current versions of the patient information leaflets were available in the clinical areas, but not all the out-of-date versions had been removed from public display.

Trust policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

We saw staff were able to access policies via the trust’s intranet. A handful of the most accessed guidelines and pathways were displayed on staff noticeboards for the convenience of quick reference.

The service was involved in local and national audit programmes, and collated evidence to monitor and improve care and treatment. There was an audit schedule for April 2017 to March 2018, with 26 obstetrics/maternity related audits. These included; operative vaginal delivery, gestational diabetes care, antenatal care, maternal request for caesarean section, reduced fetal movements, sepsis in obstetrics, and care in labour. Audits were also undertaken in response to incidents and clinical performance data, when indicated.

The action plan for the audit programme detailed the responsible person for each audit and the target date for completion. We saw that all actions had been completed, or were on track to be completed by the target date. The action plan was reviewed monthly at the obstetrics and gynaecology clinical governance rolling half day education meeting. Completed audits were also presented to staff at this meeting.

We found compliance with the *UK National Screening Committee Antenatal and Newborn Screening Programme* standards was variable. For example, in quarter two 2017/18 (July to September 2017), the service met the acceptable threshold for seven (44%) of the 16 key performance indicators however, three (19%) were not met. There were no outcomes for the remaining eight (50%) key performance indicators. This was because either the trust had not submitted the data, or the national data team did not accept the data submitted, because it was found to be unreliable.

Public Health England carried out a screening quality assurance (QA) visit in January 2018, to determine the trust’s compliance with the national antenatal and newborn screening programme (*Public Health England Screening Quality Assurance visit report. NHS Antenatal and Newborn Screening Programmes East and North Hertfordshire NHS Trust, 18 January 2018*). The report made 27 recommendations for the trust to action, in order for the service to meet national standards and national programme requirements. The QA visit team identified seven high priority findings, which included delays in taking newborn blood spot samples on day five of birth, and the antenatal pathology form did not meet national requirements. No immediate concerns were identified. The service had up to 12 months (January 2019) in which to complete the recommendations made.
In April 2017, an audit of antenatal care found there was process evidence to support compliance with NICE quality standard 22 (NICE *Antenatal care: QS22*, last updated April 2016). However, the handheld records alone did not demonstrate full compliance. For example, the audit found 57% of records showed pregnant women were cared for by a named midwife throughout their pregnancy (QS22:2) and 61% of pregnant women at risk of gestational diabetes were offered testing (QS22:6). This was below the trust target of 75% compliance. The audit results were discussed with antenatal clinic and community staff, and they were reminded to complete all required documentation.

We found compliance with NICE guidance on diabetes in pregnancy was variable (NICE *Diabetes in pregnancy: management from preconception to the postnatal period*, last updated August 2015). The results of an audit carried out from October to December 2017, showed 93% of women were appropriately screened for gestational diabetes, and all inductions of labour were appropriately timed. However, the joint diabetes and antenatal clinic team did not review women within one week from diagnosis. The average time from diagnosis to joint class attendance was 13 days, and to joint clinic was 32 days. The audit showed 68% of women had clinical contact within two weeks of diagnosis. This was however, a significant improvement from the previous year, when only 32% of women had contact within two weeks. We saw that recommendations to improve waiting times were made, such as an increase in midwifery time and the appointment of a second diabetic midwife. Issues with capacity in clinic were also being reviewed.

An audit carried out in association with the twins and multiple births association (TAMBA) showed the trust generally adhered to NICE quality standards for multiple pregnancy (NICE *Multiple pregnancy: twin and triplet pregnancies, QS46*, September 2013). For example, women with a multiple pregnancy were cared for by a multidisciplinary team (NICE QS46:1), and had a discussion about the timing of birth and possible modes of delivery by 32 weeks (NICE QS42:8).

Maternity records and discussion with staff showed that women who planned or needed a caesarean section were managed in accordance with national guidance (NICE *Caesarean section: QS32*, June 2013). For example, a vaginal birth after caesarean section clinic was offered to all women who have had a previous caesarean section. This provided women with the opportunity to discuss birth options in their current pregnancy (NICE QS32:1).

The service had implemented the *Saving Babies’ Lives care bundle* (NHS England, 2016), which was designed to reduce stillbirths, and audited adherence against its recommendations. In relation to reducing smoking in pregnancy, we found not all women had carbon monoxide testing at booking, and not all women who smoked were referred to smoking cessation services. We were told that action was being taken to improve compliance, which included additional training for staff.

The service routinely monitored fetal growth from 26 to 28 weeks gestation by measuring and recording the symphysis-fundal height (from the top of the uterus to the symphysis pubis bone). Women were routinely asked about their baby’s movements at each antenatal contact and were advised to contact the unit if they had any concerns. The consultant-led unit had a peer review system in place for the review of cardiotocography interpretation, with a protocol for escalation when indicated. This was in line with national recommendations (NHS England *Saving Babies’ Lives: A care bundle for reducing stillbirth*, February 2016).

Sepsis screening and management was generally effective and in line with trust and national guidance (UK Sepsis Trust). In February 2018, an audit of sepsis management showed 93% of patients received appropriate treatment. However, following the recognition of sepsis, only 40% of
patients received antibiotics within the first hour, which was not in line with national recommendations. Actions taken to improve compliance included an email reminder to all staff of sepsis screening and management. Laminated prompt cards were also produced for clinical areas detailing the sepsis six pathway (UK Sepsis Trust), which staff could refer to as needed.

Nutrition and hydration

Patient’s nutrition and hydration needs were identified, monitored and met. There was access to dietary and infant feeding specialists to assist women and babies when needed. Women received support and advice for breastfeeding their babies, including positioning and attachment, and hand expression. Breastfeeding initiation rates were monitored monthly. From March 2017 to February 2018, average breastfeeding initiation rates were 78%. This was higher (better) than the national average of 74% (NHS Digital Maternity Services Monthly Statistics England, January to December 2017, Experimental Statistics, June 2017 to March 2018). For the same period, an average 73% of mothers were breastfeeding on discharge from the hospital. This was in line with the trust target of 72%.

The maternity service had three infant feeding specialist midwives, who provided education and support to women and maternity staff. Infant feeding training was included in maternity mandatory training. As of March 2018, 97% of maternity staff had completed this training.

We checked the breast milk fridge on the postnatal ward, which was used to store expressed breast milk. The fridge temperature was monitored daily, to ensure breast milk was stored within the recommended range. Stored expressed breast milk was labelled appropriately, with the mother’s name, date and time it was expressed.

The hospital did not routinely provide infant formula to mothers who had made the decision not to breastfeed their baby. Mothers were informed they would need to bring their own supply of formula feed and equipment, such as bottles and teats, with them. Infant formula was provided for babies when it was clinically indicated, such as concerns about weight and hypoglycaemia (where the blood glucose level falls below the normal range), following paediatric review.

Babies at risk of hypoglycaemia were regularly monitored following delivery, to ensure they were well and maintained blood glucose levels within the normal range.

Women were encouraged to maintain their energy levels in the latent (early) stage of labour, by eating small, light meals containing carbohydrates, for slow-releasing energy, and sugary foods, for quick releasing energy. Women were also advised to drink plenty of fluids, such as water and isotonic drinks, to maintain their hydration and energy levels. Women’s hydration levels were routinely monitored and were corrected with oral or intravenous hydration techniques when indicated. This was in line with national guidance (NICE Intrapartum care for healthy women and babies: CG190, last updated February 2017).

Women were given advice on fasting before their elective caesarean section. Women were also prescribed medicines to reduce stomach acid prior to surgery. This was in line with national guidance (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

All women who underwent caesarean section received intravenous fluid to ensure they were kept well hydrated, unless contra-indicated. Post-operative nausea was managed with anti-emetic (anti-sickness) medicine, when needed. This was confirmed in the maternity records we reviewed.
Following caesarean section, women who were recovering well with no complications, could eat and drink as soon as they wished.

A dietitian saw women with pre-existing or gestational diabetes. Advice on diet to help control blood sugar levels and weight was given. This was in line with national guidance (NICE Diabetes in pregnancy: management from preconception to the postnatal period, last updated August 2015).

Glucose preparations were available in clinical areas for women with diabetes, when needed. There were stored in hypoglycaemia boxes. Glucose preparations are recommended when a patient has a ‘hypo’ and needs to increase their blood glucose levels rapidly (a ‘hypo’ is commonly used to describe hypoglycaemia).

Pain relief

Pain was assessed and managed on an individual basis and was regularly monitored by maternity staff. The service met all national standards for obstetric anaesthesia, including the length of time women waited for an epidural to be sited in established labour.

Patients we spoke with told us they were regularly asked if they needed analgesia and their pain had generally been managed well.

Pharmacological (medicine based) methods of pain relief were readily available and included ‘gas and air’, opioids (morphine) and epidural anaesthesia, which was available 24-hours a day, seven days a week.

From February 2017 to January 2018, 91.5% of women who requested an epidural were ready to receive one within 30 minutes. This was in line with the national target of 90%. National guidelines recommend that the time from which a woman requests an epidural to the time they are ready to receive one should not normally exceed 30 minutes; this period should only exceed one hour in exceptional circumstances (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

From September 2017 to February 2018, 98% of women received regional anaesthesia for elective caesarean section, 95% for emergency caesarean section grade two or three, and 70% for emergency caesarean section grade one. This was better than the national targets (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

Non-pharmacological methods of pain relief were also available, such as transcutaneous electrical nerve stimulation (TENS) machines, water and aromatherapy. The consultant-led unit had one birthing pool and the midwife-led unit had four birthing pools, which were available for women to use in labour and/or birth. From March 2017 to February 2018, an average of 11% of women who delivered at the hospital had a water birth.

The service provided aromatherapy (the use of essential oils for therapeutic effect) via inhalation, bath or massage to alleviate pain during labour.

We saw that regular analgesia was prescribed for post-operative women, including opioids and non-steroidal anti-inflammatory drugs (NSAIDs).

Women were routinely given local anaesthetic prior to perineal suturing and were offered NSAID medication per rectum (as suppositories), following perineal suturing, unless contraindicated. This
was in line with national recommendations (NICE *Intrapartum care for healthy women and babies: CG190*, last updated February 2017).

Midwifery staff provided pregnant women with evidence-based information about the availability and provision of different types of analgesia, in line with national recommendations (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*, 2013).

Parent craft classes were offered to all women and their birthing partners, and included information and advice on pain relief options during labour.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Patient outcomes were generally in line with the trust’s thresholds and national averages. The service had reduced (improved) its perinatal mortality rate.

The maternity service maintained a clinical performance and governance dashboard, which reported on activity and clinical outcomes. Performance was monitored for a range of outcomes, including normal vaginal, instrumental and caesarean section deliveries, third- and fourth-degree perineal tears, and intrauterine deaths.

The trust’s maternity dashboard parameters had been set in agreement with the clinical commissioning group (CCG). The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available (RCOG *Maternity Dashboard: Clinical Performance and Governance Score Card (Good Practice No.7)*, January 2008). There were 32 performance measures detailed on the trust’s maternity dashboard, which covered birth activity, workforce, risk management, health indicators and obstetric and neonatal clinical indicators. A traffic light system was used to flag performance against agreed thresholds. A ‘red flag’ indicated areas that required action, to ensure safety and quality was maintained. We saw that the exceptions (red flags) reported on the maternity dashboard were reviewed monthly at the risk and quality committee meetings and actions were taken to address performance issues when indicated.

According to the maternity dashboard from March 2017 to February 2018, the trust met the agreed threshold each month for:

- postpartum hysterectomies
- cases of hypoxic encephalopathy (brain injury caused by oxygen deprivation)
- maternal deaths
- perinatal deaths at more than 24 weeks gestation
- pre-labour intrauterine deaths
- serious incidents
- massive obstetric haemorrhage (excessive blood loss) greater than 2,000mls
- unit closures
- percentage of women who smoked at booking and at delivery
For the same period, the service generally met the agreed threshold each month for the percentage of home births, instrumental deliveries, cases of meconium aspiration, intrauterine deaths during labour, postpartum haemorrhage between 1,000 and 2,000mls, and third-degree tears.

The trust scored a red flag in February 2018, for three incidents of maternal admission to the intensive care unit. However, overall, they were still below the threshold of eight admissions per year. This was also the case for the number of early neonatal deaths reported. The majority of red flags were in relation to the rates of normal vaginal deliveries, elective caesarean sections and inductions of labour. From March 2016 to February 2018, the trust reported:

- The monthly average normal vaginal delivery rate was 58% (against a target of 62% or more per month)
- The monthly average elective caesarean section rate was 13% (against a target of 11% or less per month)
- The monthly average induction of labour rate was 31% (against a target of 28.5% or less per month)

For the same period, the monthly average emergency caesarean section rate was 14%, which met the trust’s threshold of 15% or less per month. The service had introduced a number of initiatives to reduce the caesarean section rate. These included weekly multidisciplinary reviews of all emergency caesarean sections to see if any were potentially avoidable. Women were also counselled about the reasons for the caesarean section and their birth options for future pregnancies, including vaginal birth after caesarean, before they were discharged from the hospital.

In relation to the England average for modes of delivery rates, we found the trust’s performance was generally similar to expected.

**Standardised Caesarean section rates and modes of delivery**

From July 2016 to June 2017, the total number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections were also similar to expected and rates for emergency sections were lower than expected.

### Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>East and North Hertfordshire NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>803</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>624</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td>1,427</td>
</tr>
</tbody>
</table>
Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery from July 2016 to June 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East and North Hertfordshire NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,427</td>
<td>26.8%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>763</td>
<td>14.3%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,141</td>
<td>58.9%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,332</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

From January to December 2017, the average monthly percentage of unexpected term admissions was 8.4%, which was higher (worse) than the England average of 5%. We were told that some of the babies included in these figures were babies only ever admitted to transitional care, and therefore should not have been reported as unexpected term admissions. However, from the data provided we were unable to calculate how many babies should have been excluded. In collaboration with neonatal care, the service had introduced initiatives to reduce the number of unexpected term admissions. This included workstreams for hypoglycaemia, respiratory distress syndrome, jaundice and asphyxia, which was in line with national recommendations (NHS Improvement Patient Safety Alert: Resources to support safer care for full term babies, February 2017). From August 2017, the service introduced fortnightly multidisciplinary team meetings where each case of unexpected admission to the NNU was reviewed. We saw that an action log and learning was identified and findings were fed back to staff to improve practice and outcomes. For November and December 2017, we saw the percentage of unexpected term admissions had reduced to 4.2% and 5.3% respectively. This meant they were in line with the England average.

The service participated in national and local audits to benchmark service provision against national standards and key performance indicators.
National Neonatal Audit Programme

In the 2016 National Neonatal Audit Programme, Lister Hospital’s performance was as follows:

- 97% of babies of less than 32 weeks gestation had their temperature taken within an hour of birth, this was slightly better than the national average of 96%
- 87% of mothers who delivered babies from 24 to 34 weeks gestation inclusive were given a dose of antenatal steroids, this was slightly better than the national average of 86%
- 76% of babies less than 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home, this was significantly better than the national average of 59%

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.43. The rate for the comparator group was 5.19. The results of the MBRRACE audit were based on the number of perinatal deaths reported by the trust in 2015.

(Source: MBRRACE UK)

This meant the trust’s perinatal mortality rate was up to 10% higher (worse) than the national average. The service had compiled an action plan in response to the MBRRACE audit report. We saw 16 out of 17 (94%) recommendations had been met. Actions required to meet the remaining recommendation had been taken and were in progress. According to the trust, the rate of stillbirths from March 2017 to February 2018 was 2.66 (per 1,000 births). Compared with the rate for 2015, this equated to a 51% reduction in perinatal mortality.

Maternity active outlier alerts

As of 31 January 2018, the trust reported no active maternity outliers and none were with the CQC panel.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive. Maternity outliers include puerperal sepsis and other puerperal infections, elective and emergency caesarean section, and neonatal and maternal readmission rates.

Competent staff

Not all medical staff had completed the trust’s cardiotocography assessment. However, managers generally appraised staff’s work performance annually, and a competency framework was in place to ensure that newly qualified midwives gained the skills and experience they needed.
Staff were required to undertake annual cardiotocography (CTG) competency assessments. This was in line with national recommendations (NHS England Saving Babies' Lives: A care bundle for reducing stillbirths, 2016). We found compliance was variable. As of February 2018, 100% of midwives had completed the assessment. However, compliance for medical staff was 71%, which was below the trust target of 90%.

All staff underwent a trust induction programme, which included mandatory and role specific training. Staff told us they had received a good induction. All midwives who were new to the trust initially worked in a supernumerary capacity alongside an experienced midwife.

Newly qualified midwives completed a comprehensive preceptorship programme to support their development from band five to band six midwives. The programme included progress interviews, reflections on practice, mandatory and maternity specific training, and competency assessments. Midwives could autonomously carry out tasks such as cannulation, perineal suturing and scrubbing for theatre when they had completed training and demonstrated competency.

Preceptorship midwives were rotated to work in all areas of the maternity service during their 12 to 13 month programme. This was generally in three-monthly blocks. Staff told us they generally felt well supported during their preceptorship. The practice development team was available to support staff. However, we were told they were only available between 9am and 5pm, Monday to Friday, and newly qualified staff felt they needed their support more at night and/or weekends.

Maternity staff had undertaken human factors training, which has been shown to improve team working, communication and patient safety (Patient Safety Collaborative).

Midwifery staff were given the opportunity to undertake additional training courses, such as the newborn and infant physical examination (NIPE) and sonography. However, some staff told us opportunities were limited, due to a lack of funding.

The statutory role of supervisor of midwives was discontinued on 1 April 2017 following changes to legislation. The trust was implementing the new A-EQUIP (advocating for education and quality improvement) model of midwifery supervision with professional midwifery advocates (PMAs). At the time of our inspection, four midwives had recently qualified as PMAs, and a further three were completing the training. The PMAs planned to provide each midwife with one-hour of restorative clinical supervision per year. Staff could also contact the PMAs via a dedicated email address, for advice and support as needed. A-EQUIP is a continuous improvement process that aims to build personal and professional resilience, enhance quality of care for women and babies and support preparedness for professional revalidation (NHS England A-EQUIP: a model of clinical midwifery supervision, 2017).

Community midwives had regular safeguarding supervision. This was provided as a group sessions or on a one-to-one basis.

Poor or variable staff performance was identified through complaints, incidents, feedback, and the annual appraisal. Staff were supported to reflect, improve and develop their practice.

Junior doctors attended protected weekly teaching sessions and participated in clinical audits. The junior doctors we spoke with told us they had specifically requested this hospital because of the training and local teaching they were given. They told us they had received a good induction and felt there was very good support from senior medical staff. The results of the General Medical Council (GMC) National Training Scheme Survey 2017 for doctors working at the trust as part of their training showed the trust was ‘within expectations’ for all 17 indicators, which
included overall satisfaction, clinical supervision, supportive environment and induction.

Appraisal rates

Arrangements were in place for supporting and managing staff, such as annual appraisals. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs. The majority of medical staff had received an annual appraisal however, the completion rate for maternity staff was below the trust target of 90%.

From April to October 2017, 76.5% of staff within maternity at the trust had received an appraisal compared to a trust target of 90%. We were unable to determine appraisal compliance rates for medical staff because the trust did not provide this information.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>29</td>
<td>33</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>62</td>
<td>74</td>
<td>83.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>120</td>
<td>171</td>
<td>70.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

As of February 2018, the appraisal compliance rate for medical staff was 92%. Maternity staff compliance had improved to 83% but this was still below the trust target. We reported similar findings at out last inspection (October 2015).

Multidisciplinary working

The multidisciplinary team worked together to benefit patients. Doctors, midwives and other healthcare professionals supported each other to provide good care.

Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering women’s care and treatment.
A multidisciplinary handover and safety huddle took place up to four times a day in the consultant-led unit (CLU), and once a day in the antenatal ward. We observed a detailed handover during our inspection, which was well attended by members of the multidisciplinary team including the obstetric medical team, anaesthetist, midwifery coordinator for the CLU, the antenatal and postnatal ward managers, clinical governance lead midwife and neonatal staff.

A separate elective caesarean section safety huddle was also held daily, Monday to Friday. We observed the safety huddle during our inspection, which was well attended by obstetric, maternity, anaesthetic and theatre staff. Each patient on the day’s operating list was discussed, and obstetric and anaesthetic risk factors were highlighted.

Meeting minutes confirmed that regular multidisciplinary meetings were held and were well attended. These included the weekly cardiotocography teaching session, the risk management group and clinical decision group meetings.

Staff reported good multidisciplinary team working. We observed this during our inspection.

Obstetrics and midwifery staff worked jointly with a number of specialities, including endocrinology, paediatrics, psychiatry, haematology, anaesthetics, and physiotherapy.

The consultant obstetrician with a special interest in perinatal mental health worked closely with the perinatal mental health team and attended multidisciplinary educational meetings at a nearby mother and baby unit.

When a pregnant woman was admitted to a non-maternity ward for treatment, obstetric and midwifery staff were involved in their management and care.

A multidisciplinary team cared for women with multiple pregnancies, which included a multiple pregnancy specialist midwife and fetal medicine specialist obstetricians. Women who needed higher levels of care were referred to neighbouring trusts with tertiary fetal medicine centres, as needed.

A member of the safeguarding team visited the wards daily, Monday to Friday, to review any women referred to them and assist with any safeguarding concerns. The team liaised closely with other professionals and agencies, such as health visitors, social workers and the community perinatal mental health team.

Community staff reported good communication with other professionals and/or agencies, such as health visitors, GPs, social services and the perinatal mental health team. Staff confirmed they were informed when a woman had suffered a pregnancy loss or had safeguarding concerns.

**Seven-day services**

Out-of-hours services were available to women 24-hours a day, seven days a week. Women could self-refer to the hospital via the emergency department or directly to the maternity unit.

Seven-day medical cover was provided with the minimum of a resident middle grade doctor. Dedicated consultant presence was available 24-hours a day, Monday to Thursday, 8.30am to 8.30pm on Friday, and 8.30am to 3.30pm at weekends. On-call arrangements were in place out-of-hours.
Anaesthetic cover was available for emergencies 24-hours a day, seven days a week. This was in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013).

There was 24-hour access to a dedicated obstetric theatre, and a theatre team was also available. The maternity triage unit was available to women 24-hours a day, seven days a week. Women (of their partners/relatives) could telephone for advices or present to the unit if they had any concerns or health issues.

The day assessment unit was open from 8.30am to 4.30pm, Monday to Friday. Out of these hours, women could self-refer to triage, the consultant-led unit or midwife-led unit.

Community midwives offered seven-day services for home births. On-call arrangements were in place 24-hours a day, seven days a week to facilitate the home birth service and provide any other advice or care to women at home, as needed.

Health promotion

People who used maternity services were supported to live healthier lives and manage their own health, care and wellbeing.

Women were offered influenza (flu) and pertussis (whooping cough vaccinations, in line with national recommendations (NICE Antenatal care for uncomplicated pregnancies: CG62, last updated January 2017). The maternity records we reviewed confirmed this.

The service had a dedicated healthy lifestyle midwife who provided dietary advice to women with a raised body mass index (BMI). They also supported women who smoked with cessation advice and support.

The smoking status of pregnant women was recorded at the booking appointment. However, we were not assured all women were offered carbon monoxide testing. National guidance recommends that carbon monoxide testing is offered to all pregnant women at the booking appointment. If a high carbon monoxide reading is identified, women should be referred to smoking cessation services (NHS England Saving Babies’ Lives: A care bundle for reducing stillbirth, February 2016). Smoking cessation services were available. From March 2017 to February 2018, the maternity dashboard showed an average of 8% of women who booked for antenatal care were smokers. This figure fell to 6% at the time of delivery.

Parentcraft classes were available for women and their birthing partners. These were designed to help prepare prospective parents for labour and birth, feeding, and adapting to parenthood.

Women diagnosed with gestational diabetes were empowered and supported to manage their own health, care and wellbeing. For example, women received dietary advice and were given appropriate equipment to enable them to regularly monitor their blood sugar levels. The trust’s website also included a 10-minute video guide, advising pregnant women how to use a blood glucose meter to assess and manage their blood sugar levels.

The service delivered elective caesarean section care based on an enhanced recovery programme, with emphasis on early normalisation to improve patient outcomes and recovery. The enhanced recovery programme focused on making sure patients were active participants in their own recovery. This included being encouraged to eat, drink and mobilise as soon as possible.
The hospital was accredited with the United Nations Children’s Fund (UNICEF) baby friendly initiative level one. This was awarded to services that promoted breastfeeding. They were working towards achieving level two.

Breastfeeding information was displayed throughout the maternity service, including guidance on the health benefits, positioning and attachment.

The trust supported national priorities to improve the population’s health. For example, the recommendations from *Saving Babies’ Lives* (NHS England, 2016) had been implemented. These were designed to reduce stillbirth rates in England.

The trust’s website contained health and wellbeing in pregnancy advice, which included smoking cessation, diet and exercise. Links to national guidance was also available, such as healthy eating, vitamins and supplements, and foods that should be avoided in pregnancy.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**

The trust had up-to-date policies regarding consent and the Mental Capacity Act 2005. Staff could access these via the trust intranet.

Staff understood their responsibilities regarding consent. Medical staff informed women about the risks and benefits of obstetric procedures, such as caesarean section. We observed this during our inspection. Written consent was obtained from women prior to surgery and we saw evidence of this in the maternity records we reviewed.

Following a serious incident, the service had written to the Royal College of Obstetricians and Gynaecologists (RCOG) to request that a potential serious fetal risk was added to the RCOG’s current consent guidance for operative vaginal delivery (*RCOG Operative Vaginal Delivery. Consent Advice No.11, July 2010*). Staff had access to specialist midwives, nurses and other professional who had particular expertise in dealing with women in vulnerable circumstances, such as those with learning disabilities and mental health concerns.

At the time of our inspection, there were no patients who were detained under the Mental Health Act 1983 (amended 2007) and none were subject to a deprivation of liberty safeguards authorisation under the Mental Capacity Act 2005.

**Mental Capacity Act and Deprivation of Liberty Safeguards training completion**

The majority of staff were compliant with the Mental Capacity Act 2005 and deprivation of liberty safeguards training. We were told that mental capacity and deprivation of liberty safeguards training was included in the programme for safeguarding adults level one and two. Therefore, 99% of midwifery and 85% of medical staff had completed training. The trust target was 90%.
Is the service caring?

Compassionate care

Staff cared for patients with compassion, kindness and respect. Feedback from patients and those close to them was positive about the way staff treated them. Patients felt supported and cared for by staff. However, the friends and family test score for postnatal ward care was generally below the England average.

We observed staff interacting with women and their relatives in a polite, friendly and respectful manner. Staff introduced themselves to women and their birthing partners and made them aware of their roles and responsibilities.

Women we spoke with were positive about the care they had received within the maternity service. One woman told us the staff were; “absolutely superb”. Another woman told us; “everyone had been really friendly”, whilst several other women described the staff as; “amazing”.

Staff displayed an understanding and non-judgemental attitude towards, or when talking about, patients in vulnerable circumstances, such as those with mental health concerns and learning disabilities.

Staff confirmed that when they assessed patient’s needs they took into account personal, cultural, social and religious needs. Patients we spoke with and patient records we reviewed corroborated this.

Patients’ privacy and dignity was respected. We saw that staff closed curtains and doors to protect patients’ privacy and knocked on doors before they entered. All women we spoke with felt their privacy and dignity was maintained. One woman told us that staff were; “very good and considerate”.

Friends and Family test performance

The service obtained patient feedback via the friends and family test (FFT), which allowed women to give feedback on their experience of maternity care provision and state whether they would recommend the service to others. There are four FFT questionnaires for maternity, which cover antenatal care, birth, postnatal care provided on the ward, and postnatal care provided in the community.

From October 2016 to October 2017, the trust’s performance for antenatal, birth and postnatal community care (where data was available), was generally similar to the England average. However, performance for postnatal ward care was generally worse than the England average.

A comparison of FFT performance for the trust and the England average from November 2016 to October 2017 is shown below.
Friends and family test performance (antenatal), East and North Hertfordshire NHS Trust

From November 2016 to October 2017, the trust’s maternity FFT (antenatal) performance (% recommended) was generally similar to the England average. The trust’s performance for antenatal care did drop to 86% in September 2017, which was lower (worse) than the England average of 97%.

Friends and family test performance (birth)

From November 2016 to October 2017, the trust’s maternity FFT (birth) performance (% recommended) was similar to the England average.

Friends and family test performance (postnatal ward)

From October 2016 to October 2017, the trust’s maternity FFT (postnatal ward) performance (% recommended) was generally worse than the England average. The trust’s performance for postnatal ward care also dropped in September 2017, with 81% of women recommending the service. This was lower (worse) than the England average of 94%. We saw an action plan had been developed in response to the FFT feedback received.
Friends and family test performance (postnatal community)

From October 2016 to October 2017, the trust’s maternity FFT (postnatal community) performance (% recommended) was similar to the England average, with 100% of women recommending postnatal community care. However, data was only available for two months (January and August 2017). We saw the service was taking action to reduce the low response rate. For example, community managers were asked to remind staff of the importance of obtaining women’s FFT feedback at team meetings. A competition asking staff to come up with ways in which to increase the response rate had also been launched.

(Source: NHS England Friends and Family Test)

We saw many complimentary friends and family test (FFT) comments from women. For example; “A truly wonderful experience, made ever great by the wonderful support we received from your staff”, “Amazing staff, very friendly, very reassuring. Made the whole experience as enjoyable as possible”, and “Very happy that we chose Lister and very appreciative of all the midwives who have been excellent from beginning to end”.

CQC Survey of women’s experiences of maternity services 2017

The trust performed similarly to other trusts for all questions in the CQC maternity survey 2017. Women who gave birth in February 2017 were invited to share their experience of the maternity care they received in the CQC maternity survey for 2017. The survey involved 130 NHS trusts in England and consisted of 19 questions, which covered labour and birth, staff during labour and birth, and care in hospital after the birth. Each question was scored out of 10 (the higher the score the better). Each trust also received a rating, which showed whether their performance was ‘better’, ‘about the same’ or ‘worse’ than most other trusts that took part in the survey.

The trust’s CQC maternity survey 2017 results are shown below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.6</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.3</td>
</tr>
<tr>
<td>Category</td>
<td>Question</td>
<td>Rating</td>
<td></td>
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<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same 9.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same 9.0</td>
<td></td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same 8.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same 8.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same 8.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same 9.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour, did a member of staff help you within a reasonable amount of time?</td>
<td>About the same 8.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same 8.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same 9.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same 8.7</td>
<td></td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same 6.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same 7.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same 8.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same 8.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If attention was needed after the birth, a member of staff helped within a reasonable amount of time</td>
<td>About the same 7.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharge from hospital being delayed</td>
<td>About the same 4.7</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)
Emotional support

Staff provided emotional support to patients to minimise their distress. Patient’s emotional and social needs were seen as being as important as their physical needs.

There was ongoing assessment of women’s mental health during the antenatal and postnatal period. The maternity service had access to perinatal mental health specialists, who provided additional care, support and treatment for women with mental health concerns as needed.

The maternity service offered a birth afterthoughts service, which provided women and their partners with the opportunity to discuss any unresolved concerns or issues they had regarding their pregnancy or birth experience.

Bereavement policies and pathways were in place to support parents in the event of a pregnancy loss, such as miscarriage, stillbirth or neonatal death. The maternity service had a specialist bereavement midwife who provided training for staff and supported families from their initial loss, throughout their time in hospital and their return home. Home visits from the bereavement midwife were available for women if needed.

The trust had a chaplaincy service, which provided spiritual care and religious support for patients, partners and relatives as needed. Multi-faith options were available. The chaplaincy service was available for support 24-hours a day, seven days a week.

The trust held annual remembrance service for anyone affected by the loss of a baby before, during or after birth.

There was access to national and local advisory groups to offer both practical advice and emotional support to women and their families. Examples included Sands (stillbirth and neonatal death charity), TAMBA (twins and multiple births association), Child Bereavement UK, and the perinatal mental health team.

Patients were enabled to have contact with those close to them. Visiting hours on the postnatal ward were from 8am to 10pm for partners and siblings, and 3pm to 5pm and 7pm to 8pm for other relatives and friends. Partners could stay overnight if they wished. Women could have up to two birthing partners with them throughout their labour and birth.

Women we spoke with told us they were offered emotional support when trying to establish breastfeeding.

We observed a positive and reassuring interaction between staff and a mother who was concerned about her baby. The staff member could see the patient was anxious, and responded calmly and offered reassurance.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Staff were committed to working in partnership with women.

Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices available to them and were given options of where to deliver their baby.
All of the women and relatives we spoke with felt involved in their care and had received the information they needed to understand their treatment and enable them to make informed decisions about their care. One woman told us; “[I was] kept informed all the way through”, and another said; “[I was] given options and information. Nothing was pushed onto me”.

We observed staff explain planned care and treatment with patients. Women and their partners were encouraged to ask questions and they were included in treatment decisions.

We saw examples of positive feedback from patients, which corroborated they felt involved in their care and treatment. For example, one woman wrote; “[Staff] were so friendly and encouraging and kept un informed throughout”. Another woman wrote; “Great communication, make you feel important”.

Senior midwifery staff and the consultant team were involved in supporting plans of care for women who made birth choices outside of trust and national guidance, such as women who requested a waterbirth or homebirth with either a current or previous high-risk pregnancy.

Birthing partners were included and involved in the care of their partner and newborn baby, including being offered the option to cut their baby’s cord at delivery. Birthing partners could attend caesarean section deliveries carried out under regional anaesthesia (epidural and/or spinal) and were able to sit beside their partner and support them throughout the procedure.

Is the service responsive?

Service delivery to meet the needs of local people

The importance of flexibility, informed choice and continuity of care was generally reflected in the services and plans for future maternity care provision. Patient’s needs and preferences were considered and acted on to ensure services were delivered to meet those needs.

The service was working closely with local stakeholders and neighbouring trusts to establish a local maternity system (LMS) and improve maternal and neonatal safety across the clinical network. The purpose of the LMS was to deliver NHS England’s priorities for maternity care provision, as laid out in Better Births (National Maternity Review, 2016) and the Maternal and Neonatal Health Safety Collaborative (NHS Improvement, 2017). The priorities for the LMS included personalised care, continuity of carer, better perinatal mental health and co-production with service users.

Antenatal care was generally readily and easily accessible to pregnant women. Women could access maternity services via their GP or community midwife. A self-referral form was also available on the trust’s website, which women could complete to access care.

Women had to attend the antenatal clinic at the hospital for their initial antenatal booking appointment. This was because community staff could not access the trust’s electronic record system. However, the trust had taken action to address this by providing community midwives with laptops. It was hoped booking appointments would be carried out in the community within the next few months.

A named midwife and/or consultant cared for women throughout their pregnancy. This was
confirmed from the maternity records we reviewed and the majority of women with spoke with. However, a few women told us they had seen different midwives throughout their pregnancy.

Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led models of care were offered to women with an uncomplicated pregnancy. This included a home birth or delivery in the midwife-led unit (MLU). This was in line with national guidance (NICE Antenatal care: QS22, statement 2, last updated April 2016). Women who had an existing medical condition, complication of pregnancy or had experienced previous complications in pregnancy and/or labour, were advised to have their baby on the consultant-led unit (CLU), which was obstetric led.

Postnatal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. A discharge letter was sent to women’s GPs and health visitors following discharge from the hospital to facilitate continuity of care.

The service had a vaginal birth after caesarean section (VBAC) clinic, which provided an opportunity for women who have had a caesarean section to explore birth choices for their current pregnancy. This was in line with national guidance (NICE Caesarean section: QS32, statement 1, June 2013).

In collaboration with commissioners and stakeholders, the service provided influenza (flu) and pertussis (whooping cough) vaccinations for pregnant women. The vaccinations were offered to women when they attended the hospital for their anomaly scan (around 20 week’s gestation).

Staff told us the uptake of influenza and pertussis vaccinations had increased since the service was introduced in November 2017. The service also offered a Bacillus Calmette-Guerin (BCG) vaccination clinic for babies who were at risk of developing tuberculosis (TB).

The facilities and premises were appropriate for the services delivered. A birthing pool was available on the consultant-led unit. This meant women who did not meet the criteria for low risk birth on the MLU, could use water for labour and/or birth if they wished.

The service had a designated bereavement room to ensure parents had time with their baby. Since our previous inspection (October 2015), the bereavement room had been refurbished. Local parents and the stillbirth and neonatal deaths charity (Sands) were involved in the refurbishment, to ensure it met the needs of bereaved women and their families. The room was en-suite and had a pull down double bed, fridge and facilities for parents and visitors to make hot drinks as they wished. The bereavement room was located at the far end of the consultant-led unit. This helped to keep bereaved parents and families away from celebrating families and the sound of live babies.

The layout of the maternity unit was designed so that women attending for antenatal appointments did not pass through the postnatal ward.

Women’s partners were able to stay overnight in the hospital if they wished. However, there were limited facilities for them to rest comfortably. The service was taking some action to improve provisions for partners. We were told a business case was being developed for the purchase of 60 reclining chairs, in order to improve partners’ experience.

The trust’s website contained comprehensive information on maternity services, including a virtual tour of the maternity unit. Other information available on the website included antenatal care, birth choices, preparation for labour, breastfeeding support groups and specialist services. The trust’s website could be translated in over 100 languages. Patient information leaflets were
also available to download from the trust website and included achieving a normal birth, induction of labour, multiple pregnancy, and vaginal birth after caesarean section.

Meeting people’s individual needs

The needs and preferences of patients were taken into account when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Bereavement care provision was in place to support families from their initial loss, throughout their time in hospital and return home.

Care and treatment was coordinated with other services and other providers, to ensure the needs of women and their families were met.

The maternity service had arrangements in place to support women with complex needs. These were managed by specialist midwives and/or consultants and included a joint endocrinology and obstetrics clinic for women with diabetes, perinatal mental health services, fetal medicine clinic, and maternal medicine clinics, which included cardiology and renal specialists.

The safeguarding team and community midwives provided care, support and treatment for women in vulnerable circumstances, such as those with learning disabilities, substance misuse, teenagers and travellers. They could refer to other health care professionals or agencies for additional support and advice as needed, such as the trust’s learning disability team, drug and alcohol team and independent domestic violence advisors.

Combined obstetric and perinatal mental health clinics were available. Perinatal mental health services were provided in collaboration with the community perinatal mental health team. Women with severe and enduring mental health needs could be referred to this service for psychological interventions, as needed. The team saw women up to 12 months after the birth of their baby.

A debriefing service was available to any women who had delivered at the hospital. The birth afterthoughts service provided women and their partners with the opportunity to discuss any unresolved concerns or issues they had regarding their pregnancy or birth experience.

The service employed a bereavement midwife, whose role was to develop bereavement care, provide support for parents and training and education for staff.

Refrigerated cots were available for bereaved parents. Cold cots slow down the natural deterioration process and mean stillborn babies can stay longer with their parents. Women could take their baby home in a cold cot if they wished.

A memory box, which included photographs and hand and footprints, were given to parents who had suffered a loss. The trust’s clinical photography department provided the professional photography service.

Parents were supported with making funeral arrangements. The hospital had a chaplaincy service, which offered spiritual and/or religious support to parents who face the loss of their baby. Chaplains of various denominations and faiths were available on request.

Parents who had experienced a stillbirth or neonatal death were offered a post-mortem examination in order to enhance future pregnancy counselling.
All women were offered fetal anomaly screening, in line with national recommendations (NICE Antenatal care: QS22, statement 10, last updated April 2016). Women identified as high risk for a fetal abnormality, such as Down’s syndrome, were seen in the fetal medicine clinic for ongoing treatment and support. Referrals to specialist tertiary centres were made when indicated.

Multiple births clinics were available, which were supported by a midwife with a special interest in multiple pregnancies. This meant women who attended the clinic had continuity of carer. We saw that the multiple pregnancy service had been rated as outstanding by the twins and multiple births association, following a recent audit.

There was a six-bedded transitional care unit situated on the postnatal ward, where care was provided by the maternity and neonatal service. This meant babies who required more specialised neonatal care, such as phototherapy for jaundice, did not require admittance to the neonatal unit and avoided separation from their mothers. However, babies who needed intravenous (into a vein) antibiotic treatment were transferred to the neonatal unit when needed, where intravenous medicines were administered. We were told the service planned to start administering intravenous medicines to babies on the transitional care unit, to reduce the separation of babies from their mothers.

Interpreter services were available for women for whom English was not their first language. These were provided face-to-face or via a dedicated telephone translation service.

Mood lighting and aromatherapy was used in the MLU to promote a relaxing and calming environment for labour and birth. Some maternity staff were trained to use aromatherapy and aromatherapy massage, which can help reduce anxiety and fear, alleviate pain, assist contraction and enhance maternal wellbeing.

The service offered women and their birthing partner’s parent education courses, including healthy development of your baby during pregnancy, waterbirth, vaginal birth after caesarean section, breastfeeding and active birth. Prospective parents could also pay for the hypnobirthing programme provided by the trust. Spinning babies advice was also offered to all women who had a prolonged labour. This had been shown to help aid optimal fetal positioning and thereby a normal, unassisted birth.

The maternity service was accessible to wheelchair users.

Women had a choice of meals, which took account of their individual preferences, respecting cultural and personal choice.

**Access and flow**

**Women could generally access the right care at the right time. Access to care was managed to take account of women’s needs, including those with urgent needs.**

Women could access maternity services via their GP, local children’s centre or by contacting the hospital directly.

From March 2017 to February 2018, an average of 83% of women had accessed antenatal care by 12 weeks and six days gestation. This was in line with the England average (NHS Digital Maternity Services Monthly Statistics, England, December 2017, Experimental Statistics, March 2018).
The National Institute for Health and Care Excellence (NICE) recommends that women should ideally be able to access antenatal care by 10 weeks, so that antenatal screening tests can be provided in a timely manner (NICE Antenatal care: QS1, last updated April 2016). From March 2017 to February 2018, an average of 66% of women had accessed antenatal care by 10 weeks gestation. This was higher (better) than the England average of 55% (NHS Digital Maternity Services Monthly Statistics, England, December 2017, Experimental Statistics, March 2018).

Routine antenatal care appointments for nulliparous (women who have never given birth) and parous (women who have given birth) women were scheduled in line with national guidance (NICE Antenatal care for uncomplicated pregnancies: CG62, last updated January 2017). This was confirmed from the maternity records we reviewed.

There was a policy in place to ensure women who did not attend appointments were followed up. We were unable to determine whether antenatal clinics ran to time because the service did not audit clinic delays. From January to December 2017, the maternity service reported 10 incidents regarding delays in antenatal clinics through the national reporting and learning system. This equates to approximately 1% of total incidents reported by the service. The delays reported were all over one hour. We saw that three of the incidents stated that delays were becoming a common occurrence. Common themes were gynaecology clinics overrunning and the late arrival of the doctor. During our inspection, we observed clinics generally ran on time.

The antenatal clinic was open from 8.30am to 4.30pm, Monday to Friday. There was a whiteboard, which staff updated with clinic waiting times. Staff also advised women of delays when they arrived.

The day assessment unit (DAU) was open from 8.30am to 4.30pm, Monday to Friday, to see women with antenatal complications. Referrals for monitoring, investigation and treatment were accepted from GPs, community midwives and medical staff. Women could also self-refer to the DAU if they had any concerns, such as reduced fetal movements. Women who needed to be monitored and reviewed regularly during their pregnancy could arrange an appointment for a time that suited them. No appointment was required for women needing urgent, immediate referral.

The newborn infant physical examination (NIPE) was performed on babies within 72 hours of birth. This was in line with national standards (Public Health England Newborn and Infant Physical Examination Screening Programme Standards 2016/17, April 2016). From August 2017 to March 2018, an average of 96% of babies born at the trust had the NIPE within 72 hours of birth. This was in line with the national standard.

Elective caesarean section lists ran six times a week, Monday to Friday. The service had a dedicated team to carry out elective caesarean section lists. Staff told us it was rare for the list to be delayed or cancelled. From January to December 2017, the service reported one incident related to elective caesarean section delay or cancellation, which was graded as having caused ‘no harm’.

An audit of induction of labour delays in February and March 2018 showed 11% (31 out of 280) of women had their induction delayed between 1.5 and 40 hours. The most common stage of delay was at the point of transfer from the antenatal ward to consultant-led unit (CLU). High acuity levels on CLU were the most common cause of delay. The audit found delays were escalated appropriately and proactively but it was not clear whether any actions to reduce delays had been identified.
Women rarely gave birth in areas not designated as labour ward. From March 2017 to February 2018, 36 babies were born before arrival or in transit to the hospital. This equated to 0.65% of total births. A further 0.1% of babies were delivered in the antenatal ward. There were no babies born in the triage unit of emergency department.

Staff told us that the flow in triage had improved since our previous inspection in October 2015. Two midwives, a clinical support worker and a dedicated junior doctor now staffed the department. Women could telephone the maternity triage unit for advice at any time during the day or night. They attended the unit for review, if indicated by the symptoms and/or concerns they described. A traffic light system using red, amber and green (RAG) ratings was used to ensure women were assessed and reviewed in a timely manner. Women were RAG rated on arrival. In addition, trust guidance stated that women who attended triage because of reduced fetal movements should have the fetal heart auscultated (listened to) within 15 minutes and cardiotocography (CTG) monitoring commenced within one hour. At our last inspection, we were told that women often waited longer than the times set under the traffic light system and staff were not clear whether the system had been audited. During this inspection, we found improvements had been made and the majority of women were seen within the time indicated by their RAG rating. The service reported that 100% of women were RAG rated, including auscultation of the fetal heart, within 15 minutes of arrival. A further 88% of women were assessed and reviewed in line with trust guidance, with the exception of women who reported reduced fetal movements, of which 100% were seen.

Staff could refer patients with mental health needs to the community perinatal mental health team or the trust’s psychiatric liaison team, who were based in the emergency department. Staff told us they received a timely response from perinatal mental health services.

Closure of the maternity unit

From March 2017 to February 2018, maternity services were suspended on two occasions. These suspensions occurred in September and October 2017. We saw evidence that the maternity escalation policy was adhered to, actions were taken to minimise the risk to women and/or babies, and the suspensions of service were investigated.

Bed Occupancy

From April 2016 to June 2017, the maternity service’s bed occupancy rate was lower (better) than the national target. Research suggests that bed occupancy rates of higher than 85% can increase the risk of harm and quality of care provided (Dr Foster, 2012). However, bed occupancy rates for the maternity service were generally higher than the England average. From Q1 (April to June) 2016/17 to Q4 (January to March) 2016/17 the bed occupancy levels for maternity were generally higher than the England average, with the trust having approximately 75% occupancy in the first three quarters of 2016/17, and 65% occupancy in the last quarter of 2016/17 compared to the England average of around 60%. The bed occupancy dropped below the England average in Q1 2017/18. No data was provided for the latest quarter.
The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Learning from complaints and concerns**

Not all complaints were dealt with in a timely manner. However, the service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Staff told us that where possible, informal complaints were resolved immediately. The service offered a debriefing service, which was available to all women and gave them the opportunity to discuss events surrounding their baby’s birth. The *Birth Afterthoughts* debriefing service was available to all women who had given birth at the trust within the last 12 months.

The service had processes in place to ensure complaints were dealt with effectively, including updates for the complainant, a timely response and explanation of the outcome.

**Summary of complaints**

From November 2016 to November 2017, there were 61 complaints about maternity. The trust took an average of 33 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be closed within 30 days.

Complaints were most commonly in relation to treatment received, communication, attitude of staff and waiting time.

(Source: Provider Information Request)
We saw evidence that action was taken in response to complaints received, in order to improve patient experience and care provision. For example, the service planned to purchase reclining chairs for the unit so that partners of women admitted could stay with them overnight, if wished. Partners were offered breakfast. A neonatal and infant physical examination (NIPE) clinic had also been established on the postnatal ward to speed up the discharge process.

Learning from complaints and feedback was shared with staff through a variety of means, such as newsletters, emails, team meetings, and noticeboards. Staff confirmed they received feedback on complaints.

We saw information leaflets and posters displayed regarding the trust’s patient advice and liaison service (PALS). PALS provided advice and support to women (and those close to them) who wished to raise a concern or complaint. Information on how to complain was also published on the trust’s website.

From March 2017 to February 2018, zero complaints were referred to the Parliamentary Health Service Ombudsman (PHSO).

Is the service well-led?

Leadership

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service was under the women and children’s division and had a clear management structure with defining lines of responsibility and accountability. A divisional director and divisional chair had overall responsibility for the division. The maternity services leadership team consisted of a clinical director for obstetrics and head of midwifery (HOM). A deputy general manager, clinical governance coordinator, clinical obstetrics lead for the consultant-led unit, consultant midwife, matrons, ward managers and specialist midwives supported the senior management team. We met with the senior management team who demonstrated knowledge of the service’s performance, challenges they faced and actions needed to address them.

The leadership team had direct access to the trust board when maternity was under consideration. The director of nursing was the board level lead for maternity services. We saw that the trust board had oversight of the service from minutes of board meetings we reviewed. Members of the leadership team told us they felt maternity services was a priority for the trust.

There was a non-executive director (NED) with responsibility for maternity services. The senior management team told us the NED was actively engaged with the service and had, for example, been part of the interview panel at the most recent recruitment of consultant obstetricians and gynaecologists.

The trust provided development programmes for staff, which supported them to develop leadership and management skills. Courses were available for first line managers, middle managers and senior managers. Staff we spoke with corroborated this.

The senior management team spoke with pride about the work and care their staff delivered on a daily basis.
The consultant-led unit was coordinated by an experienced senior midwife who, wherever possible, was supernumerary to the staffing numbers required for the provision of one-to-one care in labour. This meant they had oversight of ward activity and could support staff as needed.

Staff spoke positively about the senior management team. They told us they were visible and they generally felt well supported by managers. Not all community staff we spoke with however, felt supported by their managers and matron.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action. The vision and strategy was developed with involvement from staff, patients and key groups representing the local community.

The service had a clear vision and values, which were focused on providing safe, high quality, sustainable maternity care for all. The vision for the maternity service was; “To support each woman to have the best possible outcome for her and her baby, ensuring that she has a safe, positive experience of pregnancy and birth”. The values were consistent with the trust’s and formed the acronym PIVOT, which stood for;

- P – We put our PATIENTS first
- I – We strive for excellence and continuous IMPROVEMENT
- V – We VALUE everybody
- O – We are OPEN and honest
- T – We work as a TEAM

We saw the vision and values publically displayed throughout the maternity unit.

There was a realistic strategy for achieving the vision and delivering good quality sustainable care. The strategy was aligned to the trust’s and included; the promotion of normality and choice, increasing consultant visibility to improve clinical outcomes, developing multidisciplinary clinics, and listening and responding to the views of women and their families to develop a service which meets their needs.

Staff we spoke with knew and understood the vision, values and strategy and their role in achieving them.

In addition to the local vision and strategy, the service was working collaboratively with neighbouring trusts, clinical commissioning groups, other stakeholders and service users to establish a local maternity system (LMS) and improve maternal and neonatal care provision across the clinical network.

Following a review of the local population’s needs, as well as current maternity services provision the LMS identified its key priorities and 14 workstreams to achieve the national recommendations and ambitions laid out in *Better Births* (National Maternity Review Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care, 2016). These included; personalised care, continuity of carer, safer care, better perinatal mental health, postnatal and neonatal care, multi-professional working, working across boundaries and co-
production with service users. The LMS planned to achieve its transformation of local maternity systems by 2021, which was in line with the national ambition. Staff we spoke with were committed to providing safer care and improving the patient experience.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were committed to improving the quality of care and patient experience. However, some clinical support workers felt there were limited career development opportunities available to them.

All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the trust. Staff were committed to providing the best possible care for women and their babies.

The majority of staff we spoke with felt well supported, respected and valued by their managers. They were encouraged to raise concerns and share ideas they had for service improvement.

Obstetrics and maternity staff felt there was a positive working culture and reported collaborative and effective team working.

Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection, we observed positive and respectful interactions, which were focused on meeting women’s needs and providing safe care and treatment.

Some clinical support workers we spoke with however felt there were limited career development opportunities available to them. They also told us they felt their skills went to waste because they were frequently used to clean and make beds.

There were arrangements in place to promote the safety and wellbeing of staff. For example, the service had processes in place to protect lone workers. Community midwives attended homebirths in pairs and would also attend routine visits in pairs if they had any concerns.

The culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.

Staff were proud to tell us of improvements they had made since our previous inspection. They told us that everyone felt ownership for the service and were proud to be part of it.

The maternity service celebrated staff success. The HOM produced a weekly newsletter entitled *Special Delivery*, which included examples of compliments and kind words received from student midwives, and friends and family, as did the monthly clinical governance newsletter. We also saw examples of maternity staff successes celebrated in the trust’s *Daily News* publication. One of the midwives had been shortlisted for the MaMa 2018 midwife of the year award. A second had been nominated in the nurse/carer of the year category at the local Comet Community Awards.
Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care. The arrangements for governance were clear and operated effectively. Staff understood their roles and accountabilities.

Monthly and quarterly clinical governance meetings were held at service, divisional and trust wide level. These included the women’s and children’s speciality meeting, the clinical decision group, clinical guideline group, clinical governance rolling half day education meeting, and the women’s and children’s divisional board meeting. We reviewed 22 sets of meeting minutes, which confirmed that performance, incidents, risks, guidelines, audits, and clinical issues were discussed.

Governance meetings were well attended by members of the multidisciplinary team. The meeting minutes we reviewed confirmed this.

The maternity service used a clinical performance and governance dashboard to monitor activity, outcomes and performance. The dashboard was used to help identify patient safety and quality issues. This was in line with national recommendations (RCOG Maternity Dashboard: Clinical Performance and Governance Score Card, Good Practice No.7, 2008). The dashboard tracked monthly performance against locally agreed performance measures. The maternity dashboard was regularly discussed at departmental and divisional governance meetings. A monthly exceptions report was produced and actions were taken to address areas where locally agreed performance standards were not met. This was confirmed in the meeting minutes we reviewed.

The dashboard was also displayed on staff noticeboards throughout the unit. This was an improvement from our previous inspection in October 2015, when we found further discussion regarding the maternity dashboard was not recorded, therefore areas which may be underperforming were not monitored in a meaningful way or actions agreed if required.

The service also measured performance against key indicators, such as the NHS maternity safety thermometer, friends and family test (FFT) results, and patient safety and experience indicators, which included patient identification, medicine administration, pain control, fluid balance, and intravascular device care.

There were clear responsibilities, roles and systems of accountability to support good governance within the service. The trust had an up-to-date risk management policy, which staff could access via the trust intranet.

The clinical governance coordinator regularly represented the service at trust wide governance meetings, which included the patient safety committee, the hospital transfusion committee, medical devices committee and the risk and quality committee. They also produced a monthly clinical governance newsletter to share learning across the division. The newsletter included a brief overview of any serious incidents that had occurred during the month, with recommendations and learning listed. Current issues regarding the risk register and risk management, learning from complaints, and the reviewed and new guidelines were also included.

Staff were aware of how to complete incident reports and were encouraged to do so.

The trust had appointed maternity safety champions, in line with national recommendations (DH Safer Maternity Care: Next steps towards the national maternity ambition, October 2016). They were the clinical director for obstetrics and clinical governance coordinator.
Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service had robust arrangements in place for identifying, recording and managing risks. The divisional risk register included a description of each risk, alongside mitigating actions and controls in place. An assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring was also detailed. We saw that risks were reviewed regularly at monthly quality governance meetings and were updated when changes to mitigation had been taken.

Staff we spoke with were aware of the main risks within the service, which concerned midwifery staffing levels, the emergency buzzer system, and ultrasound scanning capacity. Information regarding the service’s risks was shared with staff in a variety of ways, such as staff and public noticeboards and newsletters.

All incidents reported via the electronic incident reporting system were reviewed daily, Monday to Friday, and where necessary investigations were initiated to identify any themes and actions needed to minimise recurrence. Any potential serious incidents were escalated to the serious incident panel for review. We reviewed the investigation reports of three serious incident investigations and found detailed root cause analyses had been completed, and included care and service delivery problems, contributory factors, recommendations and actions to be completed to reduce the risk of recurrence.

Maternal deaths, which are extremely rare, were all subject to investigation under the trust’s serious incident framework and learning was shared across the trust. Maternal deaths were also reported to the national MBRRACE-UK programme, which investigates all maternal deaths within the UK and publishes its findings in an annual report. Learning from MBRRACE-UK and other national bodies was used to inform the trust’s internal quality improvement work.

The bereavement group reviewed all cases of perinatal mortality with the aid of a national perinatal mortality tool. This was in line with national recommendations (MBRRACE-UK Perinatal Mortality Review Tool, February 2018). The service also held monthly perinatal mortality and morbidity meetings. However, we found the minutes of these meetings did not evidence what actions had been taken to minimise the risk of recurrence and/or improve patient outcomes. Lessons learned from perinatal mortality and morbidity reviews were shared at the clinical governance rolling half day.

Staff told us they received feedback on risk, incidents, issues and performance in a variety of ways, such as daily team huddles, emails, noticeboards, newsletters and social media platforms.

The service produced a quarterly booklet for staff entitled Plenty to be proud of, nothing to hide: Risks, incidents and complaints. We reviewed the winter 2017/18 update, which contained information regarding the trust’s values and vision for maternity services, improvements to service provision, the top risks and mitigation, incident themes and actions taken, complaint themes and actions taken, and learning from serious incidents.

The maternity service completed daily safety huddles whereby midwives-in-charge of clinical areas and medical staff communicated risks and key information. This ensured senior staff from each area maintained effective oversight of the daily risks within the service.
There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. This was informed by national audits and priorities, incidents and clinical outcomes. Findings from audits were shared with staff through a variety of means, which included the clinical governance rolling half day, newsletters and emails.

The service had arrangements in place in case of suspension of maternity services.

**Information management**

The service generally collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had clear performance measures, which were reported and monitored. These included the maternity safety thermometer, maternity dashboard, patient safety and experience indicators, and FFT results. Performance results were reported at ward to board level, and were used to challenge and drive forward improvements in care, where indicated.

The maternity dashboard parameters had been set in agreement with the clinical commissioning group, and were in line with national targets where available. A traffic light system was used to flag performance against agreed thresholds. Senior staff at governance and risk management forums regularly reviewed the dashboard.

There were arrangements in place to ensure the confidentiality of patient information held electronically. During our inspection, we found computer terminals were locked when not in use, to prevent unauthorised persons from accessing confidential patient information.

The service submitted data to external bodies as required, such as the national maternity and perinatal audit and MBRRACE-UK. This enabled the service to benchmark performance against other maternity providers and national outcomes. However, some of the data submitted to the NHS antenatal and newborn screening programme was not accepted because it was found to be unreliable.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

People’s views and experiences were gathered and acted on to shape and improve the services and culture. We saw evidence that service user feedback was sought to inform changes and improvements to service provision.

Women who used maternity services were encouraged to give feedback on the quality of service they received. The friends and family test (FFT) was used in both the ward areas and the community. The response rate however, for the community was poor. We saw evidence that the service was taking action to improve this.

Information about the complaints procedure and patient advice and liaison service was available in clinical areas. Feedback was also gathered through social media forums, such as NHS Choices, Facebook and Twitter.
The service used feedback from the FFT and complaints to monitor and improve services provided. We saw examples of actions the service had taken in response to feedback displayed on public noticeboards, entitled “you said; we did”. For example, the postnatal ward had introduced newborn and infant physical examination (NIPE) clinics to facilitate earlier discharges from the ward.

At the time of our inspection (March 2018), there was no maternity services liaison committee. We were told this was because the former chair had resigned and the clinical commissioning group had not yet found a replacement. Service users were however, invited to attend the delivery suite forum and clinical guideline group meetings. Minutes of the meetings we reviewed corroborated this.

The service had introduced a number of schemes to improve and encourage staff engagement since our previous inspection in October 2015. For example, once a month a new scheme, based on local and national initiatives for service improvement, was launched. We observed the launch of the Better Births Day during our inspection. This involved senior staff carrying out a tea and cake trolley run across all maternity wards and departments, informing staff of the initiative and inviting them to get involved in one of the ten Better Births workstreams, such as personalised care, safer care and better perinatal mental health care. Staff were encouraged to sign up to the workstream they were interested in and submit an idea, no matter how big or small, of how the service could implement that workstream in practice.

The service also used social media networks to engage with staff. The closed social media page, for example, had a different themed message for each day of the week. These included “make a difference Monday”, “welfare Wednesday”, and “thankyou Thursday”. Staff we spoke with told us these initiatives had made a big difference and they felt empowered to share ideas for service improvement.

We saw effective team working across all clinical areas.

There were positive and collaborative relationships with external partners and stakeholders to build a shared understanding of challenges within maternity and the needs of the local population, and delivery of services to meet those needs. The service was working collaboratively with service users, neighbouring trusts and commissioners via the local maternity system (LMS), to ensure national recommendations for maternity care were implemented across the region.

The minutes of meetings we reviewed showed good staff engagement at all levels.

Staff told us they felt confident to raise concerns with managers.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Staff of all grades were committed to improving service provision and the patient experience. We saw examples of service improvements and innovations on noticeboards throughout the maternity unit. For example, a nursery nurse had developed a daily observation and feeding prompt chart to ensure babies who needed observations and/or feeding support were reviewed as needed.
As part of their launch of the professional midwifery advocate (PMA) role, the service held a competition for midwives to design the trust’s PMA logo. The selected logo has since been chosen as the national PMA logo.

The service was engaged in the LMS and was working collaboratively with local trusts, stakeholders and service users to improve maternity care provision for the local population.

There was an established perinatal mental health service, which included psychiatry, psychology and specialist perinatal mental health nursing staff, to assist and improve the delivery of mental health care within the service.

A successful bid with Health Education England enabled the maternity service to invest in additional training courses, such as human factors and resilience training. Some members of staff were qualified to teach human factors training and they planned to roll this out across the trust and the local trusts within the LMS.
Services for children and young people

Facts and data about this service

East and North Hertfordshire NHS Trust provides child health services to children and young people living in East and North Hertfordshire as well as parts of South Bedfordshire across two hospital sites. The two hospital sites are the Lister Hospital and the QE11 Hospital.

This evidence appendix will only focus on services for children and young people provided at Lister Hospital. The services at the QE11 Hospital were not inspected.

The children and young people’s service at the Lister Hospital provides outpatient and inpatient facilities, as well as emergency and elective surgery for babies and children up to the age of 18. Children aged 16 and over have the option of being treated on an adult ward, if preferred. The service consists of a level two neonatal unit, a children’s ambulatory care unit (CAU), The Mulberry Suite which comprises a paediatric ward (Bluebell ward), and Bramble ward which includes a day unit providing oncology services, specialist clinics and the Bramble suite, a dedicated examination and interview centre for children suspected of being subject to abuse.

The trust has 45 inpatient paediatric beds located in three wards, all within the Lister Hospital.

- Neonatal unit: 22 beds
- Bluebell ward: 16 beds
- Children’s ambulatory care: seven beds

The trust also has a safeguarding suite (Bramble suite) and children’s A&E also at Lister Hospital both with no beds reported.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute)

The paediatric ward (Bluebell) comprised of 16 beds with capacity for 20 beds. There were two bays of six beds and eight single rooms which were open for patient care. Facilities were available for parents to stay. Children up to 16 years were cared for on Bluebell ward. There was a large play area which linked with Bramble ward, a separate sitting room and bathroom for teenagers, and an area for children who were immunocompromised. There was also an outdoor play area.

The neonatal unit had 28 cots. There were four intensive care cots, six high dependency cots, and 18 special care cots. There were two isolation rooms. The neonatal unit had a room for expressing breast milk, a private consultation room and two single and two double rooms to enable parents to stay.

The trust had 7,569 patient spells from November 2016 to October 2017.

Emergency spells accounted for 85% (6,400 spells), 13% (1,003 spells) were day case spells,
and the remaining 2% (166 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from November 2016 to October 2017, East and North Hertfordshire NHS Trust.

![Percentage of spells chart]

Total number of children’s spells by Site, East and North Hertfordshire NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>This trust</td>
<td>7,569</td>
</tr>
<tr>
<td>England average</td>
<td>1,097,997</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

The last comprehensive inspection of this service was October 2015 and was rated requires improvement for safe, effective, responsive and well led and good for caring. The service was rated as requires improvement overall.

We carried out our inspection of Lister Hospital from 20 to 22 March 2018. During our inspection we inspected clinical areas in the service including Bluebell ward, the Bramble suite, the neonatal unit, and theatre recovery.

We spoke with eight patients and parents, and 41 members of staff, including consultant paediatricians, junior doctors, nurses, play specialists, ward clerks, domestic staff and managers. We observed care and treatment, reviewed patient care records and medicine prescription charts. We also reviewed the trust’s performance data and looked at paediatric and neonatal trust policies.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it. Medical staff mandatory compliance was poor.

Mandatory training topics covered key areas such as life support, infection prevention and control and fire safety. Staff accessed mandatory training through face to face and online courses.
However, we were told that when the clinical areas were short of staff mandatory training was cancelled. Individual staff and their managers were informed by the learning and development team when training was due.

**Mandatory training completion rates**

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

A breakdown of compliance for mandatory courses from April to October 2017 for medical/dental and nursing/midwifery staff in children’s services care is shown below:

**Medical/Dental Staff:**

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Staff Trained</th>
<th>Staff Eligible</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>56</td>
<td>69</td>
<td>81.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>56</td>
<td>69</td>
<td>81.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>55</td>
<td>69</td>
<td>79.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>55</td>
<td>69</td>
<td>79.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>48</td>
<td>69</td>
<td>69.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>47</td>
<td>69</td>
<td>68.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>26</td>
<td>69</td>
<td>37.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 71%. Of the seven mandatory training courses delivered by the trust to medical and dental staff, none met the completion rate target of 90%.

We were told that medical staff could not complete their Personal Development Plan (PDP) without their mandatory training being up to date however the trust target for mandatory training was not met.

All surgeons and anaesthetists had Advanced Paediatric Life Support (APLS) and European paediatric Advanced Life Support (EPALS) training. All medical staff we spoke to had undertaken APLS training. Medical staff told us that they were able to access study leave.
Nursing Staff:

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Staff Trained</th>
<th>Staff Eligible</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>128</td>
<td>136</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical</td>
<td>127</td>
<td>136</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>(including management of inoculation injuries &amp; hand hygiene)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>127</td>
<td>136</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>127</td>
<td>136</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>116</td>
<td>127</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>123</td>
<td>136</td>
<td>90.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>119</td>
<td>136</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>114</td>
<td>136</td>
<td>83.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff was 90.9%. Of the eight mandatory training courses delivered by the trust to nursing and midwifery staff, six met the completion rate target of 90%.

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

We were told by three specialist trainers for new-born life support (NLS training) compliance had fallen from 90% in 2016-2017 to 72% due to funding issues. This had been raised at board level. This was recorded on the risk register and was due to a decrease in regional continual professional development funding for NLS courses.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.

Staff demonstrated an understanding of safeguarding issues and were able to identify concerns that would prompt a safeguarding referral including neglect, physical, emotional and sexual abuse. Staff were able to describe the actions they would take to raise a safeguarding concern and were well supported by the safeguarding team. If a safeguarding concern was raised staff would liaise with other professionals including GP’s, health visitors, school nurses, and social workers. However, staff’s awareness of what they would do if there was a case of female genital mutilation or child sexual exploitation was variable.

Safeguarding information was displayed on Bluebell ward to inform parents and visitors of the safeguarding team and how to raise any safeguarding concerns if necessary.

There were routine admission processes to check if safeguarding concerns had previously been identified or if relevant checks had been undertaken. However, knowledge of this system was
limited on the ward. Staff told us that they would check on an electronic data management system as safeguarding concerns would be identified there.

A mandatory “Think Family” page required completion on the electronic record system. Staff would consider the impact of parental issues on children for example mental ill-health, the use of illicit drugs and alcohol. Child sexual exploitation (CSE) was recorded on the “Think Family” page and reported on the safety dashboard. The safeguarding team liaised with the police and had arranged for them to speak with staff about CSE and local behaviours. The trust had developed a new policy for female genital mutilation (FGM). Specific training was delivered from the Hertfordshire Safeguarding Children’s Board (HSCB) about FGM which was disseminated to staff by the safeguarding champions. Safeguarding champions are link nurses from each department who meet with the safeguarding team on a monthly basis to disseminate information to ward staff.

We saw effective handovers between multidisciplinary teams which highlighted safeguarding issues and updated staff on actions taken. One of the safeguarding nursing team attended a daily multidisciplinary handover and provided advice and guidance on the management of all safeguarding issues. Weekly multidisciplinary psycho-social meetings were held where safeguarding issues were discussed. We saw that relevant safeguarding checks and referrals had been made where necessary. We were told that a liaison service was in place and all under five year olds attending the hospital were reviewed with any concerns being shared with the local authority and relevant staff. Staff told us that if children or young people missed two or more appointments the safeguarding team would be informed. The safeguarding team was accessible to all staff and was visible within the trust. We were told that they operated an “open door” policy.

The safeguarding team attended daily safety huddles to inform staff of safeguarding issues. They worked closely with local agencies including the police and Hertfordshire safeguarding children’s board (HSCB). The trust reported eight child protection incidents since October 2017. Three of these had been reported by children’s services and five by maternity services. The safeguarding team reviewed all incidents, risks and complaints within their clinical governance meeting and reported to the children’s board and women and children’s divisional board. Actions taken and feedback to the reporter were documented within the incident reporting management system. Learning was disseminated to staff through trust wide safeguarding training, peer review and supervision. The safeguarding champions would also disseminate information to teams.

Assessments of children and young people (CYP) when there was suspicion of abuse were held in the Bramble ward by a multiagency team. A sexual behaviours traffic light tool was used to support staff working with children and young people to help them assess and respond appropriately to sexual behaviour in children and young people, understand healthy sexual development and distinguish it from harmful behaviour.

There was a named safeguarding nurse for children and a named paediatric safeguarding doctor who were available to provide support to medical and nursing staff when they had concerns about a child or young person. Safeguarding supervision is a Department of Health requirement, as detailed in ‘Working Together to Safeguard Children’ (2010). Safeguarding supervision was available for all nursing staff, either on a one to one basis or in small groups. Medical staff
received peer review supervision.

There are five levels of safeguarding training, levels one, two, three, four and five. The Intercollegiate Document, ‘Safeguarding children and young people: roles and competences of health care staff (March 2014)’ states that ‘all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns must be trained to level three. Named lead professionals must be trained to level four. Designated doctors and nurses must be trained to level five’. All nurses, medical staff, healthcare assistants and play specialists working in the children’s service had access to level three safeguarding children training, as recommended. The trust safeguarding training policy states that staff on wards where 16-18 years may be placed should be trained to level two. However, training compliance varied for surgery and medicine. All paediatric staff had received level three safeguarding children training.

The trust had an absconding policy, however most of the staff we spoke with were unsure of this.

The trust had just ratified a new chaperone policy (February 2018) which stated that it was mandatory for all children and young people under the legal age of consent (16 years) to be seen in the presence of another adult.

**Safeguarding training completion rates**

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

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental and nursing/midwifery staff in children’s services is shown below:

**Medical/Dental Staff:**

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Staff Trained</th>
<th>Staff Eligible</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>58</td>
<td>69</td>
<td>84.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>58</td>
<td>69</td>
<td>84.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>47</td>
<td>69</td>
<td>68.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>47</td>
<td>69</td>
<td>68.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall medical safeguarding training completion rate was 76.9%. The trust met the completion rate target for one of the five safeguarding modules it delivered.
Nursing Staff:

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Staff Trained</th>
<th>Staff Eligible</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>135</td>
<td>136</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>135</td>
<td>136</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>127</td>
<td>136</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>127</td>
<td>136</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>117</td>
<td>131</td>
<td>89.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s overall nursing safeguarding training completion rate was 95%. The trust met the completion rate target for four of the five safeguarding modules it delivered.

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

Cleanliness, infection control and hygiene

Staff did not always use control measures to prevent the spread of infection such as handwashing.

Standards of cleanliness and hygiene were well maintained, the neonatal unit (NNU) was clean and tidy, Bluebell ward was older and more cluttered, but clean. Bramble ward was clean but we observed equipment left on the floor and on a chair of a treatment room.

Regular infection prevention and control (IPC) audits were completed within the children and young people’s department. In NNU cleaning staff were employed by an external contractor. Cleaning audits were undertaken regularly and were reported to achieve 98-99%. Hand hygiene audits were undertaken in clinical areas with occasional spot checks from the infection control team. A quality indicators audit for January 2018 was seen in NNU and scored 100%. On Bluebell ward an ICP audit for February 2018 scored 83% with a ward cleanliness audit score of 99%. A daily cleaner cleaned the play areas on Bluebell ward. The specialist play area for oncology patients was cleaned daily by the cleaners and by play therapists in between patients. The play specialists and ward volunteers cleaned the toys.

Hand sanitiser was available at the entrances of all clinical areas and in the wards and single rooms. We observed most staff washing their hands before and after seeing patients. However, we saw that neither staff nor parents always washed their hands on entering or leaving nurseries on NNU. There was also limited evidence of staff using hand sanitisers in NNU. We saw that hand sanitisers had been moved from the sink areas and had been positioned behind portable equipment making them difficult to access.

Most staff in all areas adhered to “bare below the elbows”. We saw most staff washing their hands and wearing gloves and aprons to undertake clinical work. There were sufficient supplies of protective equipment. However, we did observe some medical staff with full length sleeves.
Side rooms were available on both NNU and Bluebell ward to admit children or babies with a known or suspected infection. Signs were not always displayed to identify this. One room on Bluebell ward did not have a barrier nursing sign in place but stated “oncology bed” indicating that the patient was at greater risk of acquiring an infection.

In all clinical areas we inspected, we saw the correct segregation of clinical and non-clinical waste into different coloured bags and all waste bins were foot-operated and clean. We saw that staff had labelled sharps bins, the bins were not over-filled and they were out the reach of children.

There was a flushing schedule for taps to prevent infection thriving, for example, legionella (a bacterium that can flourish in water systems). A system was in place to ensure this was completed.

There were no cases of MRSA or Clostridium difficile reported since April 2017. Babies and children were screened for MRSA on admission.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 8.6 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 and Young People’s Survey 2016, RCPCH)

Environment and equipment

Premises were not always suitable and equipment was not always looked after according to manufacturer’s instructions. Not all areas were secure, there were ligature risks for which the risk assessment was out of date, a heater was not appropriately covered and the milk fridge was not locked with recorded temperatures out of range and appropriate action not consistently taken.

The entrance to both the Mulberry Bush Children’s Unit and neonatal unit were through locked double doors which were controlled by an intercom system. There were also security cameras at the entrances to these clinical areas with the footage from these cameras displayed at the ward desks. This meant that staff could identify visitors and ensure children and babies were kept safe. This area was manned by the ward clerk when on duty. However, when the ward clerk was not working, parents frequently waited for long periods to access the unit.

Entrance to some of the utility areas on the neonatal units had key pad locks although not all rooms were locked. On Bluebell ward there were keypad locks on some utility and treatment rooms. However, there were no locks or high handles on the sluice door, no cupboard locks in the sluice and lotions were stored in low unlocked cupboards. We found microbiology swab sample tubes containing transport medium and a skin spray in unlocked low-level cupboards in the ward area. The equipment storage room on Bluebell ward did not have a lock and had an exit door into a yard outside where there were waste bins. The external door could not be opened from the outside but it was possible to exit the ward from this door and walk a short distance to the main road. We raised these concerns with ward staff and the matron who immediately removed the items from the cupboards and said that they would arrange for key pads to be fitted to the doors.
Following our inspection, the key pad locks had not been fitted as the issue had not been raised as a high security risk. We asked the ward manager to follow this up. We were told that the estates department would be fitting locks within the next two to three days. A lock could not be fitted to the equipment storage room door as it was a fire exit and had to remain accessible. However, the door handle was going to be raised so that children would not be able to reach it.

The toilets and bathroom facilities were clean and generally well maintained. There was a disabled toilet available in the corridor outside Bluebell ward but it was out of order. The toilet was repaired following the inspection. Baby changing facilities and emergency call bells were located in the cloakrooms, however there were no emergency call bells located in individual toilets on Bluebell ward and none of the sinks were low enough for smaller children to use. The lack of emergency call bells in the toilet cubicles was not on the risk register. The doors were heavy and the handles were all high.

Some patients admitted to Bluebell ward were admitted with mental health issues. We observed potential ligature risks within the children and young people’s department. For example, on Bramble ward there were call bells with cords in the toilets. A risk assessment had been undertaken of the ligature risks but it was out of date and due for review November 2017. The risk assessment was requested following the inspection but did not indicate when the risk assessment was to be reviewed. There were ongoing quarterly checks of areas with ligature hazards. However, no incidents had been recorded within the department.

The bathroom doors on Bramble ward could be locked from the inside but had to be opened with a key from the outside. There was therefore a potential risk for a child to be locked in the bathroom. The ward manager told us that there were potentially numerous ligature risks on Bluebell ward and how those risks were reduced. There had been no reported incidents in relation to mental health or ligatures on the ward. Following our inspection, we requested a copy of the ligature risk assessment which identified that an action plan was in place which included ongoing safety checking. This had been due for review in November 2017 but no review was recorded.

In the play room area between Bluebell ward and Bramble ward we saw that a wall heater was uncovered and situated at a low level, posing a potential risk to children putting their fingers in the open ventilation part of the heater causing a burns risk.

All electrical equipment we checked during our inspection, apart from two, were electrical safety tested to ensure they were safe to use. Two fans in Bramble ward were out of date for testing. We saw “I am clean” stickers on equipment in most clinical areas including patient weighing scales, baby scales, infusion and monitoring equipment. We did not see “I am clean” stickers on some equipment on Bramble ward.

Paediatric and neonatal resuscitation equipment was easily located and had been checked daily. The resuscitation equipment contained varied sizes of equipment to cater for the range in ages and sizes of children. We saw from checklists that staff checked the defibrillator and tamper tags daily. In theatre we saw that the paediatric resuscitation trolley was checked daily and opened weekly by theatre staff, and monthly by the resuscitation officer. Appropriate sized equipment was in evidence. We were told that on adult wards where older children may be nursed for example 16-18 year olds, smaller equipment was available if necessary.

We checked the milk fridge on the neonatal unit, expressed milk was dated and labelled, however the fridge was not locked nor was the milk kitchen. This posed a potential risk that milk could be tampered with. Fridge temperatures were checked but recorded elsewhere. We observed that
fridge and freezer temperatures were invariably out of range. A process was in place to address this but it was not being consistently adhered to.

Senior staff in the neonatal unit identified that there was no long term sustainability plan to replace aging equipment. This meant that as equipment aged there was a greater risk of it breaking down.

We observed that electrical plug sockets were not covered on Bluebell ward. We were also told that the ward sometimes became very warm. This was not identified on the risk register. In the play room area all windows would only open a little way so there was no risk of a child climbing out. The separate adolescent and oncology patient rooms were clean and well maintained.

Children on Bluebell and Bramble wards had access to an outside play area for use during good weather.

There was a daily check list for the bay areas on Bluebell ward which included items for staff to check. This included for example call bells in full working order, paediatric and adult facemasks, suction and hand sanitiser present. We saw that over the previous few weeks there were several occasions when the checklist had not been completed every day, therefore we could not be assured that equipment was always present and in full working order.

In the neonatal unit there had been occasions when sewage had leaked up through the plugs in the showers in two of the parents “rooming in” rooms. This posed an infection control risk. Nursing staff, support workers and the contracted cleaning company would regularly check these areas and would review when babies were in the room. The estates department would attend if there was a problem reported. This concern was recorded on the risk register however we could not be assured that this issue was being permanently addressed as there was no time scale indicated for when any work would be undertaken.

There was exclusive use of the day surgery unit for children two days per week. Children’s nurses undertook assessments of children undergoing surgery. There was a separate children’s area with a dedicated entrance and play area, and only paediatric patients were in recovery. Children were recovered from their anaesthetic near to the nurses’ station. Staff told us they supplied toys for children. Staff would always take an emergency “grab bag” when escorting a patient back to Bluebell ward in case of emergency as it was a five minute walk from theatres. We were told that adults may be recovering from an anaesthetic in a separate recovery area nearby however this area was divided by curtains and met national guidance.

Guidance on the Provision of Anaesthesia Services for Pre-operative Assessment and Preparation (2016) states ‘children should be separated, ideally visually and audibly from adults and should be managed and treated in child-friendly areas, including waiting rooms, pre-assessment clinic rooms, and theatre areas, including anaesthetic and recovery areas, as far as possible”.

Assessing and responding to patient risk

Potential risks to the service were not always anticipated and planned for in advance. Risks to people who use the service were not always assessed and their safety was not always monitored and maintained. Harm reviews were undertaken on patients who had waited the longest rather than clinical need, there was a delay with discharge summaries, audits of sepsis showed some poor compliance.
Comprehensive risk assessments were undertaken for children and young people who used the service. We saw that several clinical systems were in place to monitor patients and several screening tools were used to assess risk for example the screening tool for the assessment of malnutrition in paediatrics (STAMP), a validated nutrition screening tool for use in hospitalised children aged two-16 years and visual infusion phlebitis score (VIP) charts were completed. If patients required additional observation staff were able to provide this.

Nursing staff used age appropriate paediatric early warnings score (PEWS) tools to monitor and manage deteriorating patients. This included a full set of vital signs (heart rate, respiratory rate, temperature, blood pressure, pain score and oxygen saturations). Staff plotted the observations against pre-determined parameters. There were clear actions to take when the PEWS increased and indicated a patient was deteriorating. The service used a hand held electronic system which alerted the nurse in charge and the medical staff if a patient was deteriorating. The system relied on the staff receiving the information about a deteriorating patient to physically acknowledge it. However, this did not identify what actions had been taken. Staff told us that they also verbally communicated any concerns to senior nursing and medical staff. Unqualified staff were unable to submit information and had to have any evidence countersigned by a qualified member of staff. We saw that one patient had been commenced on oxygen overnight but medical staff had not been informed until the morning. We could not be assured therefore that this system was embedded.

Sampling and auditing of all waits over 18 weeks had been validated and staff told us that a harm review would be undertaken for all patients waiting over 40 weeks if harm was identified. Harm reviews had been undertaken on the two patients who had waited under 52 weeks and who had not come to harm. 29 patients waited 52 weeks for an outpatient appointment. A harms review was carried out and there was no harm reported for any of these patients Harm reviews had been undertaken on patients that waited the longest for an appointment rather than on patient risks or clinical needs. Therefore, we were not assured that the harm review process in place captured all potential patients at risk whilst waiting for appointments.

The admission pathway was described with nursing observations taken on arrival, the patient seen by a doctor within one hour. We were told that the maximum wait for “at risk children” was one hour. If there was a longer wait there was a consultant to consultant review. General surgical consultants who were on call did not have routine commitments and were therefore available to see children and young people quickly.

Children were prioritised if they required surgery and would be operated on at the beginning of a surgical list. This meant that they did not have to spend more time than was necessary without anything to eat or drink. Staff told us that consultant general surgeons who were on call did not have other routine commitments to attend to therefore they were available for surgery. Consultant paediatricians were available for advice and support seven days a week. Deteriorating patients care was escalated by the data management system so that changes in patient’s conditions were escalated and addressed more quickly. Staff told us that the hand-held data management system had gone live in September and had made a positive difference to patient care and there was more ability to escalate information about deteriorating patients more quickly.
Staff told us that critically ill children would be managed and stabilised either in the resuscitation area of the emergency department, theatres or the intensive care unit prior to transfer to a specialist unit if necessary.

A pathway was in place for assessing jaundice. However, we saw that the pathway could result in a child not being reviewed by a post registration doctor. We raised this with the trust who told us that junior doctors were closely supervised by a consultant until they were deemed competent. However, they trust told us that they would review their process of assessment for prolonged jaundice.

There was no paediatric intensive care unit but there were two funded high dependency beds. Bluebell ward had side rooms which they used for patients with higher dependency needs. Processes were in place to transfer children requiring urgent critical care. Good multidisciplinary working was described between departments for example critical care, surgical and paediatric teams. Consultant to consultant discussion occurred and the child would be stabilised either in the resuscitation room of the emergency department or would be transferred to theatre if necessary prior to transfer to a specialist hospital. Staff told us there was good communication with the transfer teams.

The NNU was a level two unit, neonates who required more intensive support for example those born under 27 weeks gestation, or those over 27 weeks who required more intensive care were transferred to a level three unit as close to home as possible which was in accordance with Bliss guidance.

Children and young people with mental health needs were admitted to Bluebell ward. We saw that a staff member had developed a care plan for the ward for the “safe care of children and young people in emotional crisis”. However, we saw that the care plan template did not include any emotional support that the patient may require, was not discussed with patients or relatives nor enabled patients or carers views to be recorded.

Staff knew how to access additional support for children and young people with mental health needs. The trust had a service level agreement with mental health services. A C-CATT child and adolescent mental health service covered Lister hospital and were available to call from 9am to 9pm Monday to Friday and on Saturday and Sunday mornings. An on-call psychiatrist was available after hours for advice and would refer to the C-CATT team. Support was also available from child and adolescent mental health services (CAMHS), psychology support could be accessed through an internal referral system and weekly psycho social meetings were held which were led by the safeguarding team. Additional mental health training was available for staff from a consultant psychiatrist. One of the ward nurses acted as a link nurse for mental health.

We reviewed two sets of patient’s records, both of which had identified current mental health concerns. Appropriate assessments and referrals had been made and the ward was supported by a Mental Health Act administrator to ensure that all legal documentation was in place. Staff had taken appropriate actions to maintain the patient’s safety whilst on the ward.

We attended patient handover safety huddles between medical and nursing teams in all areas.
Clear and effective handovers were observed which highlighted identification of areas of concern and provided a good identification of risk, for example if PEWS were raised this was highlighted and discussion occurred about patient progression and expected pathways to be followed. Staffing and workload issues plus patients for discharge or transfer were also discussed at this time.

We saw evidence of the sepsis six pathway on wall charts and in-patient notes which described the signs of sepsis (the presence of harmful bacteria and toxins in the body) and action to take, for example, completing the ‘Sepsis Six’ pathway in the patient’s notes and immediate escalation to medical staff. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It consists of three diagnostic and three therapeutic steps to be delivered within one hour of the initial diagnosis. Sepsis audits were completed quarterly as part of the trust’s monitoring of patient’s outcomes to assure themselves that children and young people were having rapid, effective treatment according to national guidelines. However, the service recognised that due to the random sampling techniques used there were low numbers of children’s information recorded. Staff identified through the audit process that explicit sepsis screening documentation was poor, sepsis proformas were not completed and there were long delays before intravenous antibiotics were commenced. Bespoke training was being provided, bespoke posters were available to remind staff about sepsis screening and the “red flags” to watch out for, nursing and medical sepsis champions and leads were being recruited and patient assessment documentation was being reviewed.

The main theatres, treatment centre and day surgery unit all complied with the five steps to safer surgery checklist. Step one is the team briefing or “huddle” where the team discussed the order of the surgical list and any concerns before starting. The World Health Organisation (WHO) form accounted for steps two to four and is completed for each patient. Step five is a team debrief at the end of the list where a quick discussion of what went well and what did not should take place.

At the end of every patient’s surgery the WHO forms were audited in recovery to ensure that they were correctly completed before being filed in the patient’s notes. A real time audit was carried out in a selection of patients to ensure the process and WHO data capture was complete and accurate. The trust’s audit tool (WHO surgical safety checklist) was used to ensure that each step had been followed correctly during surgery. A sample of these audit forms were reviewed and steps taken to address areas of non-compliance. Results were sent to the operating theatre manager, clinical lead for surgery, head of nursing for surgery and to the clinical audit governance department. We observed staff carrying out the WHO checklist. Staff completed the steps correctly and the checklist forms we reviewed were all signed, dated, and fully completed.

The trust had decided to decrease the frequency with which it audited the 5 steps to safer surgery WHO checklist due to general good compliance. Main theatres, treatment centre and day surgery all complied with the 5 steps to safer surgery. The next audit was due to be completed in January 2018. The results of this audit have been requested, results received identified that from January 2018 to March 2018 94%-98% of audit form questions were completed and between 60%-100% audit forms completed. However, these results were for the whole service.

Quarterly febrile neutropenic audits were completed in line with our POSCU (Paediatric Oncology...
Shared Care Unit) status.

The service told us that they did not specifically audit for surgical site infections (SSI’s) in children and young people CYP. However, they had a surveillance system that monitored all SSIs and CYPs service had not been identified as an area for concern.

There was a set of locked doors linking the Bramble suite to Bramble ward. However, on entering the corridor leading to the Bramble ward and Bluebell ward we observed that the double doors into the Bramble ward were open on every occasion we entered the area. The play rooms on Bluebell ward linked directly with Bramble ward and enabled children to play freely. However, this meant that it was possible for a child to leave either of the ward areas, access the main corridor and potentially leave the department either accompanied or unaccompanied by an adult or for someone to access Bluebell ward from the playroom. This door was also a fire door. These concerns were raised with staff during our inspection. They reported that leaving the door into the corridor open had been risk assessed. We were told that a swipe card facility was being requested. We saw this concern was recorded on the risk register and an action plan was in place to obtain quotes for swipe card access and to review the process of access to the playroom. Following our inspection, the trust told us they had taken action to lock the door from Bramble ward into the play room. There was no access from Bramble ward through to Bluebell ward and therefore the potential risk of a child leaving the area unaccompanied was removed. We were also told that the door onto Bluebell ward was broken and would not close automatically therefore security for patients could not be assured. Ward staff had reported this to the estates department for urgent repair and ensured that parents closed the door properly to maintain patient safety.

The neonatal unit had 28 cots which included seven Intensive therapy cots (ITU), four high dependency (HDU) cots and 16 special care baby unit (SCBU) cots. The NNU recorded ITU and HDU patient observations on specific charts, these included temperature, heart rate, respiration rates, oxygen saturation levels, mode of ventilation and ventilation pressures. We reviewed three observation charts and saw that they were completed fully. A care bundle was in place regarding sepsis and antibiotics were prescribed and given to a baby within one hour if risk factors identified this in line with Royal College of Emergency Medicine (RCEM) Clinical Standards for Sepsis. However, on examining the drug charts it was evident that babies were having oxygen but it was not being prescribed nor was there a patient group direction (PGD). A PGD is a document signed by a doctor and agreed by a pharmacist which can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. This was raised with the clinical lead and pharmacist during our inspection. No immediate action was taken; therefore, we were not assured that oxygen therapy was being administered appropriately.

Staff accurately recorded visual infusion extravasation (VIE) scores in the care plan and could describe the process to follow when the VIE score had increased. Care bundles and patient pathways were utilised, for example a care bundle was in place for the identification and treatment of necrotising enterocolitis (NEC) which the department had been involved in the development of with the local neonatal network. A nutrition pathway was being utilised which was
benchmarked three monthly against the local neonatal network.

Neonatal simulation scenarios were regularly undertaken for the management of neonatal resuscitation. This scenario incorporated members of the multidisciplinary team, including paediatricians, anaesthetists, healthcare assistants and nurses.

The service had a backlog of approximately 75 discharge summaries and approximately 100 children were lost to follow up for waiting list appointments due to the introduction of a new data management system in September 2017. This meant that there was a potential risk of patients not accessing follow up treatment or investigations in a timely manner. The service had organised medical staffing to address the backlog of discharge summaries and harm reviews were being undertaken. This was to be reviewed in December 2017 but more children lost to follow up had been found. It was identified on the risk register that some patients on the waiting list had not had appointments since 2014. This included 137 children waiting over 52 weeks for appointments. Consultants received copies of the patient treatment list so that they could review the numbers of children waiting for appointments. There was no clear system to identify which patients were at greatest risk as those waiting the longest were prioritised.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.3 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.2 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)’? This was worse than other trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
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<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
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<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
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<td>About the same as other trusts</td>
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<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.2</td>
<td>Worse than other trusts</td>
<td>S4</td>
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(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Nurse staffing**

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
The trust has reported their staffing numbers below for year of 2016/17 and year to date which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
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<td></td>
<td>Actual</td>
<td>Planned</td>
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<tr>
<td></td>
<td>staff</td>
<td>staff</td>
</tr>
<tr>
<td>Children and young people</td>
<td>106</td>
<td>133</td>
</tr>
</tbody>
</table>

The fill rate for nursing staff in 2017/18 year to date was higher than in 2016/17.
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

**Vacancy rates**
From December 2016 to October 2017, the trust reported a vacancy rate of 17.5% in children’s services. This was higher than the trust target of 6.0%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

During our inspection in 2016 nursing staff vacancies in women’s and children’s division was 8%. Information received from the trust for March 2018 demonstrated that the total vacancy rate was 14% for children’s services with the vacancy rate for qualified staff 9%.

**Turnover rates**
From December 2016 to October 2017, the trust reported a turnover rate of 10.2% in children’s services. This was below the trust target of 12.7%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
From December 2016 to October 2017, the trust reported an average sickness rate of 5.4% in children’s services. This was higher than the trust target rate of 3.3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift. This was planned at four registered nurses and one non registered nurse for 16 beds. If the actual number of nursing staff did not meet the planned number beds would be closed. However, some shifts were not always fully staffed compared to the number planned and in accordance with national guidance. From 18 March 2018 to April 18 there were 14 shifts, a mixture of days and nights that did not meet the planned establishment of shifts on Bluebell ward. On each of these shifts there was one registered nurse short. The ward manager told us that this was because of long term sickness and that on each of these occasions beds were closed to maintain patient safety. These staffing issues had been reported at a bed meeting but we could not be assured that they had been reported as incidents.

The children’s service used an electronic staff rota system that took into account staffs’ qualifications and specific skills. The system ‘flagged’ when there was not an appropriate trained nurse on each shift, such as a nurse trained in high dependency care or European paediatric advanced life support (EPLS).
On Bluebell ward we saw rotas planned six weeks in advance with a band six, band five and support staff on duty. A band seven was also on the rota and would undertake clinical work when necessary. Four staff were on duty on most shifts with 16 beds open on the ward. The matron would work clinically where necessary. Student nurses on rotational placements would also work on the ward. Staff told us that they enjoyed working on Bluebell ward and that vacancy rates were much lower than at the previous inspection in 2016. The nurse in charge would be planned to be supernumerary but if undertaking clinical duties would try to take the lowest dependency patients. However, we were told that this also depended on skill mix on the ward.

RCN guidance states that there should be:
- One nurse to three patients for children under the age of two years.
- One nurse to four patients for patients over the age of two years.

The guidance also states that ‘the standard for a general inpatient ward should reflect the age of the child as well as acuity’.

We saw that appropriate and timely escalation was taken to address any shortfall in staff. Staffing concerns were discussed and addressed at every ‘safety huddle’. When staffing levels did not meet the acuity of patients, the ward manager escalated this to the matron. A senior manager attended daily safety huddle meetings where staffing numbers were discussed and reported onto “Safecare.” SafeCare is a staff rostering tool endorsed by National Institute for Health and Care Excellence (NICE) Safe Staffing guidance (SG1) to support safe staffing levels based on skill mix and patient acuity. Paediatrics met safe staffing levels at the time of our inspection.

Staff on Bramble ward told us that they were short staffed and that two band five staff nurse vacancies were currently being advertised. When the ward was short staffed we were told that staff had their mandatory training or other education cancelled to cover the ward. Staff told us that there “was a good team spirit” and they would work late if necessary and take time owing if staffing levels allowed. However, the matron told us that each morning a senior manager attended the “hub” where staffing numbers were reported onto “Safecare” an electronic system to compare staffing levels and skill mix to actual patient demand therefore safeguarding patient safety. Areas were RAG (red, amber, green) rated depending on patient acuity and dependency. Staff from “green” areas were moved to “red” areas to provide cover with the aim of having no red areas by the end of a shift.

Staff told us that senior staff worked clinically when required, however the nurse in charge would try to care for the lower dependency patient’s. During our inspection, we observed the matrons attending the clinical areas to support staff, discuss activity and any issues that had arisen. We were told however that it would be helpful to have a senior paediatric nurse bleep holder available at night.

In the neonatal unit nursing staffing rotas were seen with qualified in speciality (QIS) nurses, registered nurses and support nurses on duty. BAPM standards were not consistently met due to the number of babies on the unit. On the days that we inspected BAPM standards were met. We were told that if the unit was busy senior nurses would work clinically.
BAPM guidance recommends a ratio of:
- One nurse to one patient in intensive care cots
- One nurse to two patients in high-dependency cots
- One nurse to four patients in special care cots

The risk of inadequate staffing levels on the neonatal unit was identified on the risk register and it was recognised that recruitment was difficult.

The paediatric service had worked hard to recruit staff both nationally and internationally. Seven staff of all grades had been appointed to the neonatal unit and had either commenced in post or were due to start soon. Two further staff vacancies had been filled on Bluebell ward with a vacancy for one band five staff nurse and two band five nurses on Bramble ward. Staffing levels in the neonatal unit were reviewed monthly through the “Special meeting”.

All staff that we spoke to enjoyed working within the paediatric area and the team working between all staff.

**Bank and agency staff usage**

Bank staff were used to ensure gaps in the rota were filled, for example, to cover sickness or annual leave. The children’s service tried to use the same bank staff to cover shifts, where possible. This assisted with safe staffing levels and promoted continuity of care for patients. Ward staff completed induction checklists with temporary (bank) staff and ensured staff were familiar with the ward layouts and emergency procedures. We were told that the trust had significantly reduced the number of agency staff being used and were using more bank staff. Regular bank staff were available and we were told that work was available.

Nursing handovers happened at the change of each shift. We observed that the handovers were well structured and concise. Handover meetings took place in office and meeting room areas to ensure that patient confidentiality was maintained. A staffing hub was also attended with all specialities represented. Repetitive information was shared at this meeting.

The nursing handover on the neonatal unit occurred in a seminar room which ensured privacy. Staff were allocated to patient’s dependent upon their expertise. The matron also attended a huddle in the maternity unit to gain an overview of potential admissions to the neonatal unit. A further medical handover occurred with senior nursing representation. This was concise, used the SBAR (situation, background, assessment and recommendation) communication tool and identified risks and concerns.

**Medical staffing**

**Medical staffing levels within the children’s service were sufficient to provide safe care and treatment at the time of the inspection.**

There were well-structured medical handovers three times a day, which included discussions about staffing issues, priority patients and transfers. Consultants were present at two handovers per day; this was in line with the RCPCH guidelines. Medical handovers were also attended by
junior doctors with a member of the safeguarding team attending once. Daily consultant led ward rounds were held on Bluebell ward and the neonatal unit including the weekends.

All grades of medical staff (junior, middle grade and senior/consultant grade) were available 24 hours a day, seven days a week. The junior and middle grades were on site 24 hours a day. Consultant anaesthetists were available 24 hours a day.

The trust has reported their staffing numbers below for year of 2016/17 and year to date which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Children and young people</td>
<td>64</td>
<td>60</td>
</tr>
</tbody>
</table>

For both years the trust has had more staff in post than planned.

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

**Vacancy rates**
From December 2016 to October 2017, the trust reported a vacancy rate of -8.2% in children’s services, indicating that they were over establishment. The trust target is 6%.

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

**Turnover rates**
From December 2016 to October 2017, the trust reported a turnover rate of 4.4% in children’s services. This is below the trust target turnover rate of 12.7%.

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

**Sickness rates**
From December 2016 to October 2017, the trust reported an average sickness rate of 1.1% in children’s services. This is below the trust target of 3.3%.

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

**Bank and locum staff usage**
We were told that additional locum cover was employed to manage a backlog of discharge summaries. In NNU a locum was employed to support with winter bed pressures, however this post did not commence until March 2018.

**Staffing skill mix**
In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average.
Staffing skill mix for the 51 whole time equivalent staff working in children’s services at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>40%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

The service provided anaesthetic cover specifically for paediatrics. Emergency surgery operating lists were covered by a consultant on call rota with critical care consultant support if necessary.

Acute paediatric consultant cover was provided from Monday to Friday 8:30am – 5pm with a ward consultant on site. A CAU consultant was on site 8:30am to 4:30pm and from 4:30pm - 9pm. Between 9pm - 8:30am there was on-call consultant cover.

At weekends there were 8:30am to 8:30am shifts with consultant paediatricians on site between 8:30am to 1:30pm and 8pm to 10pm, otherwise consultants were on call from home.

There were four neonatal consultants and one locum. Neonatal consultant cover was from Monday to Friday 8:30am to 5pm with a consultant on site and 5pm to 8:30am a consultant was on-call.

At weekends consultants were on site for the morning ward round then on call from home. Thereafter, there was an on-call consultant available to advise or attend the hospital, as required.

The service had increased consultant cover by two in children and young people services to enable children to be seen within 14 hours.

There was dedicated 24 hour neonatal consultant cover with four consultants and one locum consultant.

Records

Staff kept appropriate records of patient’s care and treatment. Records were clear, up to date and available to staff providing care.
Children’s services used both paper and electronic records. Both nursing and medical records were combined which provided clear documentation of a patient’s journey. We reviewed nursing and medical records and observed excellent medical record documentation on the ward round on Bluebell ward. The records combined the use of all results and trends, observations, and a clinical audit tool. Electronic records were also used, for example a hand-held data system which provided historical information. There was a facility within the hand held electronic system to identify specific needs for individual children, for example if a child was subject to a child protection plan or had mental health issues. If there was deterioration in PEWs scores the system enabled staff to alert both the senior nurse and the medical team so that appropriate action was taken to manage the patient’s condition. Another electronic patient data system had been introduced in September 2017. Since its introduction there was confusion about patient data with duplications and patient’s information lost within the system for example there were approximately 100 children’s information lost to follow up since the introduction of the system. This information was recorded on the risk register.

We saw staff making paper notes at handover. We were assured by staff that these were destroyed at the end of the shift. However loose paper could be mislaid causing potential breaches of confidentiality to occur.

We saw that PEWs charts were completed and deterioration was escalated appropriately. On the neonatal unit we saw that summaries were completed within the records, consent was evident and notes corresponded with clinical charts.

Medical and nursing notes were kept in locked trolleys. In the neonatal unit the trolleys were locked and the nurse in charge held the keys to access the records. However, we observed on two separate days that the medical and nursing notes trolley was not locked and was open on Bluebell ward. This meant that there was a risk of unauthorised people gaining access to medical records.

We observed the use of parent held child records or “red book” (PCHR) where medical interventions and height and weight were recorded. This ensured that up to date information about children was available when they sought health care advice.

On discharge, children, young people and their parents were given written information and relevant contact details in case they needed extra support.

**Medicines**

Medicines were not always prescribed given, recorded and stored in accordance with best practice. Patients did not always receive the right medication at the right dose at the right time, medication doses were missed or drugs were unavailable.

There were 14 episodes of medication errors reported on the neonatal unit from October 2017 to March 2018 and 22 episodes on Bluebell ward when medication had been prescribed, prepared or administered incorrectly or were not available. Staff had also reported incidents where medication errors had occurred when patients had been transferred from other hospitals, for example poor communication occurred as to whether a drug had been given. This resulted in the drug being given twice. We saw that the service had taken appropriate actions following these incidents and applied duty of candour.
Oxygen was identified as having been administered on both the NNU and Bluebell ward without a prescription. We were told that target oxygen saturation levels were used to identify if oxygen was required. Oxygen is a prescription only medicine which should be administered in line with a prescription, a protocol or a patient group direction. A patient group direction (PGD) is a written instruction for the sale, supply and/or administration of medicines patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription to groups of patients who may not be individually identified before presentation for treatment. (NICE guideline MPG2, 2017). We raised the concerns with the pharmacist during our inspection. We were not assured of the safe administration of oxygen therapy.

We saw that not all fridge temperatures were checked and recorded on the neonatal unit or on Bluebell ward consistently. In the Neonatal ward (NNU) we found that temperature logs were generally well kept but there were some omissions. However appropriate action was not always taken when fridge temperatures were out of range. We were informed that the fridge freezer temperatures could be adjusted up or down but there was no guidance on appropriate parameters. There was no system in place on NNU to check the fridge freezer temperatures once they had been adjusted. Cleaning logs for fridges were not completed.

We reviewed medication charts on Bluebell ward, allergies and contra-indications to antibiotics were identified on each page. Each chart had been reviewed by a pharmacist. However, patient's names were not on every page in one chart.

All antibiotic prescriptions must be reviewed within 24-72 hours of initiation. The review of antibiotics was documented in 38% of the eligible prescriptions (antibiotics continued beyond 72 hours). There were no results for Bluebell ward however NNU reported 100% compliance. The service provided feedback of the results to the divisions and the trust, microbiology teaching sessions for doctors and pharmacists were arranged and re-audit was planned for at least once a year.

In the NNU we found that medicine fridges were not locked but were located in a locked room. There was out of date stock in the bottom of the fridge. The controlled drugs register was generally well kept, however we found evidence of missing signatures on one entry and another entry with no signatures at all. We also found an out of date controlled drug on Bluebell ward and missing signatures. This was raised with nursing staff but the drug was still in the cupboard the following day. The Nursing and Midwifery Council Standards for Medicine Management (2007) recommends that the checking and administration of controlled drugs should be witnessed by a second signatory who should be another registered health care professional.

**Incidents**

Patient safety incidents were not always managed well. Staff recognised incidents but did not always report them appropriately. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong staff apologised and gave patients honest information and suitable support.

The hospital used an electronic online system for reporting incidents and staff were encouraged to report them. All staff we spoke with described the process for reporting incidents; however, not all staff could provide examples of the types of incidents they would report. Most staff told us they
would report medication incidents, such as missed or incorrect doses of medication, or if there was an incident in the clinical area. However, very few staff told us they would complete an incident report if the clinical area was understaffed. Outcomes and actions from incidents were shared with staff at staff meetings and debriefs occurred with staff. Some staff told us that they did not receive feedback from their manager about incidents reported on the incident reporting system or did not know how to access it. All staff told us they received direct feedback when they had been involved in incidents. In some areas meeting were not always minuted so we could not be assured of the feedback and learning from incidents.

During our inspection in 2016 staff did not always report incidents and feedback was not always provided on incidents reported.

In the neonatal unit incidents were discussed at ward meetings. We saw minutes of meetings which corroborated this. Meeting minutes were emailed to all staff. We were told of learning from incidents, for example we were told that following incidents of babies with low temperatures being admitted from the labour ward discussions had occurred with maternity services to ensure that processes were followed to reduce this risk.

Most staff were aware of serious incidents that had occurred and knew how to report a serious incident. There was evidence of learning from incidents for example a new pathway had been introduced for appendicitis following a serious incident. We saw that this was being used.

Responses to national safety alerts were carried out according to trust policy and process. The alerts were sent out from the trust central source and received by key individuals within the service including the head of nursing. Actions were assessed and taken according to relevance.

Staff told us that duty of candour was applied when incidents occurred. Staff we spoke to knew what duty of candour meant. Staff described a working environment in which any errors in a patient’s care or treatment were investigated and discussed with the patient and their relatives. The trust had a policy relating to duty of candour, which outlined actions to be taken when something went wrong. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents were reviewed and discussed at meetings which included rolling half days, clinical governance, monthly incident reporting meetings and team meetings. These were attended by paediatricians, obstetricians, managers, nurses and midwives. Incidents were also a standing agenda item at the monthly directorate and divisional governance meetings. Minutes of team meetings on the neonatal unit were emailed to staff.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for children’s’ services.
Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported 2 serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from January 2017 to December 2017.

These were:
- Treatment delay meeting SI criteria with one (50% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with one (50% of total incidents).

Representatives from children and young people’s services attended regular mortality and morbidity meetings. Consultants carried out reviews of each death within the service. De-briefs were held for all staff, medical, nursing and support staff both internal and external to the organisation, offering both clinical and emotional support. Cases were reviewed by the matron, head of nursing and lead consultant or clinical director for the clinical area to identify areas of clinical concern. The trust serious incident policy and guidance would be followed and actions or changes in practice identified, implemented and documented. Action plans would be developed and monitored through the service and speciality governance and board meetings. Information and learning was shared through a number of avenues including the trust rolling, half day sessions, speciality meetings, junior teaching, consultant meetings and clinical area meetings and newsletters.

We were told that there was an overarching paediatric panel to review child deaths. Paediatricians were involved in reviewing deaths involving young people between 16-18 years old.

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 no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2016 to December 2017 for children’s services.

(Source: NHS Digital)
The results from the NHS Safety Thermometer were not publically displayed on Bluebell. This meant patients and visitors were not aware the service achieved 100% harm-free care provided.

**Is the service effective?**

**Evidence-based care and treatment**

The service used current evidence-based guidance and best practice standards to inform the delivery of care and treatment. Pathways were written in line with the National Institute for Health and Care Excellence and Royal College of Paediatrics and Child Health guidelines.

Patient care was planned, assessed and delivered in line with national guidance. The neonatal service was accredited to the Bliss baby charter. Staff told us that they were working towards United Nations Children’s Fund (UNICEF) baby friendly level one accreditation.

There was an effective system in place to ensure policies and guidelines had been developed in line with national guidance, including the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Policies were up to date, available via the trust intranet system and staff demonstrated they knew how to access these. We reviewed policies, clinical guidelines and care pathways which included an integrated care pathway (ICP) record for children and young people with diabetic keto-acidosis which demonstrated clear advice for management and assessment and followed relevant national guidance and a policy for risk management for neonates.

A clinical governance group meeting was held monthly to review and develop clinical guidelines. Trainee doctors had the opportunity to participate in this. However, some medical guidelines were out of date but there was a system in progress to address this. The neonatal unit participated in the development of guidelines at trust level, locally and through the local neonatal network. Staff in all areas had opportunities to participate in the development of guidelines and pathways.

The service participated in national audits for example national paediatric diabetes audit (NPDA), epilepsy 12, mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRACE) and national neonatal audit programme (NNAP). Action plans were developed as a result of national audit outcomes, for example a business case was being developed to recruit a diabetes nurse educator within the children and young people’s division to improve patient outcomes by providing optimal self-management education. Sepsis audits were completed quarterly together with quarterly febrile neutropenic audits. Local audits were undertaken including record keeping, observations (PEWS), environment and handwashing. Compliance had lapsed in some areas from January to March 2018, managers recognised this and an action plan was in place which included the development of a specific audit link role and clear escalation process. From January to March 2018 30 PEWs records had been audited by managers and compliance was recorded at 96%.

Audits were undertaken of antimicrobial prescribing compliance. It was expected that all prescribers working within Lister Hospital follow the trusts approved guidance when prescribing antimicrobials. An antimicrobial point prevalence audit carried out on 22nd November 2017 across all wards in Lister Hospital. On the 22nd of November there were a total of 586 patients in the
wards included in the audit. From those, 557 were audited (95%). A total of 221 patients (39%) were on antibiotics accounting for a total of 269 antibiotic prescriptions.

Children and young people were assessed for mental health conditions and followed up appropriately. The service had a link nurse for mental health and additional support was available from the child and adolescent mental health (CAMHS) team and a consultant psychiatrist. We saw evidence of appropriate referrals and assessments under the mental health act for children and young people at risk of suicide and self-harm.

Children and young people were assessed for autism which adhered to NICE guidance (NQS51). The service linked with continuing care and community nursing teams. Staff described how they would deal with violence and aggression.

**Nutrition and hydration**

*Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other preferences and age appropriate nutrition was provided.*

There was a multidisciplinary approach to providing age appropriate nutrition for children and young people. Fluid and nutrition charts were used to monitor appropriate fluid and dietary intake.

Fluid and nutrition charts that we reviewed were accurate and up to date. Neonatal feeding plans and feeding charts were reviewed and up to date, ensuring babies received age appropriate nutrition and hydration. Monthly audits were undertaken of fluid charts. From January to March 2018 30 fluid balance records had been audited and compliance was recorded at 96%.

Support and specialist advice was available from the dietetic department. Dietetic support was available for children and young people with specific conditions for example diabetes and cystic fibrosis. Specialist speech and language therapists were available for swallowing assessments and advice and support. Staff knew how to access these services.

On the neonatal unit there was a breast milk fridge for the storage of expressed breast milk (EBM) so that babies could be tube fed their mother’s breast milk. Breast pumps were available for mothers to use and advice and support to breastfeed was provided by nursing staff and a breastfeeding counsellor.

**Pain relief**

*Patients’ pain was assessed and managed well.*

Patient’s pain was well managed and routinely assessed and recorded. The FACE pain scale was used to assess pain. The FACE scale shows a series of faces ranging from a happy face at zero which represents "no hurt" to a crying face at 10 which represents "hurts worst."

In all clinical areas we observed that pain was effectively managed. We saw that the appendicitis and abdominal pain pathway had been used effectively. Pain was thoroughly reviewed and the use of analgesia was discussed at paediatric medical handovers and on ward rounds. We also observed that staff focussed on pain management optimisation regarding oncology care.
Distraction techniques were used to distract children from painful procedures and topical anaesthesia was available for children and young people before cannulation or venepuncture. The service had a specialist nursing pain team. Although this was predominantly an adult service the specialist pain nurse visited Bluebell ward daily and staff could contact her for advice to review patients and to manage pain appropriately. Some nurses had been developed to act as “pain champions” to support staff in assessing and managing patient’s pain.

**Patient outcomes**

**Effectiveness of care and treatment was monitored findings were used to improve outcomes. Local results were compared with those of other services to learn from them. These results showed that the service was performing within expectations for diabetes but there was a higher than average readmission rate for under one year olds.**

**Paediatric diabetes audit 2015/16**

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%)”.

The data below shows that in the 2015/16 diabetes audit the trust performed within expectations:

- The proportion of patients receiving all key care processes annually was 30.8% which was within the expected range, compared to a national aggregate of 355%. The previous year’s score was 32.8%.
- The average HbA1c value (adjusted by case-mix) at the trust was 66.6% which was within the expected range, compared to a national aggregate of 68.3%. The previous year’s score was within the expected range.
- The organisational performance compared between years shows clinically significant improvement.

(Source: National Paediatric Diabetes Audit 2015/16)

**Emergency readmission rates within two days of discharge**

From September 2016 to August 2017 no speciality at the trust had six or more emergency readmissions after elective admission for the under one age group or the 1-17 years old age group.
Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment specialty (September 2016 to August 2017)

No treatment specialty reported six or more readmissions.

Emergency readmissions within two days of discharge following elective admission among the 1-17 year old age group, by treatment specialty (September 2016 to August 2017)

No treatment specialty reported six or more readmissions.

The tables below show the percentage of patients (by age group) who were readmitted 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.

The data shows that from September 2016 to August 2017 there was a higher percentage of under one year olds readmitted following an emergency admission compared to the England average and a higher percentage of patients aged one-17 years old readmitted following an emergency admission compared to the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>East and North Herts NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.8%</td>
<td>2,165</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

<table>
<thead>
<tr>
<th>Specialty</th>
<th>[Trust name]</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.4%</td>
<td>4,038</td>
</tr>
<tr>
<td>General Surgery</td>
<td>3.2%</td>
<td>186</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From October 2016 to September 2017 the trust had limited data for the percentage of patients under the age of one who had multiple readmissions for asthma, diabetes or epilepsy.

The trust performed better than the England average for the percentage of patients aged one-17
years old who had multiple readmissions for asthma and for the percentage of patients aged one-
17 years old who had multiple readmissions for epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>East and North Herts NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>01-17</td>
<td>15.7%</td>
<td>102</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>01-17</td>
<td>*</td>
<td>39</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>00</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>01-17</td>
<td>21.2%</td>
<td>33</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)

**National Neonatal Audit Programme**

In the 2015 National Neonatal Audit Lister hospital’s performance was as follows:

Do all babies under 1501g or a gestational age of under 32 weeks at birth undergo the first retinopathy of prematurity (ROP) screening in accordance with the current guideline recommendations?

100% of the 66 babies eligible for this standard were screened, above the national average of 98%.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

Of the 747 episodes eligible for this metric, 89% were seen within 24 hours, which is just below the England average of 90%.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

Rates of survival are better than the England average with 0% dying post discharge compared to the England average of 1%. The risk of severe impairment is 14%, which is higher than the England average of 10%.
What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

Definition of Bronchopulmonary Dysplasia:

A. Mild: respiratory support (Ventilation, CPAP, BiPAP, HHFNC and or any oxygen) on day 28 + air at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

B. Significant: respiratory support on day 28 + respiratory support at 36 weeks corrected gestation or from the time of discharge if discharged earlier.

Of the 175 babies eligible for this metric, 65% had no BPD and 26% had significant BPD, both of which are better than the England averages of 52% and 31% respectively.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

The children’s service had developed action plans to address the findings from the audits. The service also reported the NNAP performance indicators on the women’s and children quality and outcomes dashboard each month. We saw a copy of the action plans and minutes from the annual audit review meeting. Audit meetings were held regularly throughout the year.

The trust told us that sepsis audits were completed quarterly as part of the trust quality assurance process and quarterly febrile neutropenic audits were completed in line with their POSCU status. We requested this information from the trust, but it wasn’t provided.

Competent staff

Staff were competent to undertake their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Although the appraisal rate had not met the trust target of 90%, over 83% of staff had received an appraisal.

Staff attended both trust and local inductions. The children’s and young people’s service had developed induction packs for all staff new to the service. When new staff commenced in post they would work in a supernumerary capacity for a short time to become familiar with the department and the processes. For example, staff in the neonatal unit would work under direct supervision for the first six to eight weeks in post. Competencies packs were developed to ensure that staff developed the skills and knowledge to undertake their roles safely and effectively. For example, there were competencies for health care support workers to work in the milk kitchen preparing feeds for babies. We saw competency packs in the neonatal unit with evidence that staff had successfully completed them. Staff who had returned from extended periods of sick leave also had to complete competencies. All new staff were supported by the clinical educators to help their development.

Student nurses gained experience within the departments had mentors who they would work alongside and who would sign off their competencies. We were told that there were good educational links with the university and course tutors would visit students whilst they were on placement. Mentors had regular updates with the university to maintain their competencies.
The service had developed link nurses in a variety of specialities for example there were infection prevention and control and mental health link nurses. Link nurses liaised with the specialist teams for example infection control and mental health teams and would cascade information within their clinical areas. There were also champions for pain control and safeguarding. Safeguarding champions regularly met with the safeguarding team and disseminated information to staff. “Train the trainer” roles had also been developed where staff were trained to teach staff members how to use specific equipment safely, for example infusion devices, multichannel monitors and incubators.

Staff that worked on Bramble ward, which was mainly outpatients had specific competencies for example dermatology and haematology to meet the needs of the children attending these clinics.

Training was available for all staff regarding mental health issues. Staff had requested this to ensure that they provided appropriate care for patients. From December 2017 to February 2018 the child and adolescent mental health (CAMHs) team had agreed to participate in both the paediatric and emergency department team time sessions. A variety of topics were covered including children and adolescent depression or low mood, eating disorders, self-harm, over dose and suicidal ideations, family relationships and the impact on the child/young person’s mental health, autistic spectrum disorder, absconding behaviours and challenging behaviours. This education was to continue and would also include input from the eating disorder team.

The neonatal unit maintained good links with the local neonatal network and participated in the development of pathways for example the necrotising enterocolitis care bundle, research and training. Specialist trainers would provide education within the unit for example neuroprotection training. Simulation training took place within the departments to enable staff to train together to manage complex situations, for example in the management of a child with a pneumothorax (a collapsed lung).

Competency packages had been developed in collaboration with the local neonatal network to ensure staff were competent in all areas of care. All paediatric staff were supported by practice educators to develop their practice and competence

The service had developed specialist nurses, for example those who were qualified in specialty (QIS) in both neonatal and paediatric nursing, pain control, an infant feeding co-ordinator and outreach nurses. We were told that two nurses were currently undertaking a neonatal course to be qualified in speciality. 68% of staff held an accredited post registration qualification in specialised neonatal care.

There were three specialist trainers for new-born life support (NLS training) in the neonatal unit. However, we were told that compliance had fallen from over 90% in 2016/2017 to 72%. The specialist trainers told us that this was due to funding cuts and had been raised at trust board level. This was not on the risk register.

All surgeons and anaesthetists had advanced paediatric life support (APLS) and European paediatric advanced life support (EPLS) training. All medical staff we spoke to had undertaken APLS training. Medical staff told us that they were able to access study leave.

There was a dedicated medical lead, eight paediatricians and four neonatologists. There was a dedicated team of anaesthetists who worked with the paediatric team and would see all paediatric patients. This ensured that they had the right skills and expertise and effective team working
occurred. Staff told us that they had developed a triangulated approach to managing winter bed pressures which had worked well and incorporated the maternity, neonatal and paediatric units.

Consultant job plans had recently been updated. Consultants told us that recent changes had been made to job plans regarding transition clinics for children and young people. Junior doctors confirmed that they felt well supported by the consultants and clinical director and were receiving good training. There were established links with the university and one tutor at the trust had recently won awards for best trainee unit and best tutor of the year.

Medical staff told us that they felt supported by senior staff and received supervision. Junior medical staff completed induction training in paediatrics which included the identification of sick children, new-born examination and procedures in new-borns which included the assessment of jaundice in new-born infants.

Medical staff that we spoke to felt supported and had ongoing educational development. The service liaised with the community paediatric service to provide consistent and ongoing care for patients.

Most medical and nursing staff we spoke to told us that they felt well supported by senior staff. Nursing staff did not receive formal clinical supervision but received supervision following any significant episodes. We observed good examples of teaching on the ward rounds and at staff handovers. We were told by medical staff that the quality of the nurses in paediatrics and CAU was excellent and had contributed to “fantastic outcomes”.

**Appraisal rates**

From April 2017 to October 2017, 83.2% of staff within children’s services at the trust had received an appraisal compared to a trust target of 90%. No information was provided for medical staff working in children’s services. A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>99</td>
<td>116</td>
<td>85.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>50</td>
<td>59</td>
<td>84.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Staff completed an annual appraisal as part of their personal development review. Staff told us that they found the appraisal process beneficial and could suggest additional training they wanted to complete. For example, the service funded specialist courses in neonatal or paediatric nursing. All staff that we spoke with told us that they had had an appraisal and had the opportunity to identify areas for their own development. For example, one nurse was given the opportunity to work with oncology patients following her appraisal which had increased her confidence.

Revalidation was introduced by the Nursing and Midwifery Council in 2016 and is the process nurses and midwives must follow every three years to maintain their registration. The practice educators supported staff throughout the revalidation process.

**Multidisciplinary working**

Staff worked together as a team for the benefit of patients. Medical staff, nurses and other healthcare professionals supported each other to provide care.

Staff throughout the trust worked closely together to provide effective multidisciplinary working to ensure that children and young people were provided with safe care. Staff liaised with all members of the team including school nurses, health visitors, community paediatric nurses, social workers and GP’s. GP’s could access telephone advice from the paediatric team. We saw that there were forms in place to provide written information for community staff and continuity of care. Liaison was good with the safeguarding team.

We observed good interactions between medical and nursing staff on the neonatal unit, Bramble and Bluebell wards during ward rounds and handovers. The nurses and medical staff we spoke with also confirmed that there was good multidisciplinary working between them. There were daily multidisciplinary team ward rounds led by a consultant paediatrician, safety huddles and medical handovers. A member of the safeguarding team attended one handover daily and provided advice as necessary. We saw discussions about children with complex needs who had been identified as needing occupational or physiotherapy when discharged. Staff knew how to contact other professionals for advice. We saw that patient care and management was reviewed and discussed within the multidisciplinary team taking child and parental views into account for example a discharge was delayed so that a parent could collect older siblings from school. We saw from comments in the results of the CQC Children and Young People’s survey 2016, Q36.
that this was happening

Nursing and medical handovers identified children and young people with additional needs so that appropriate referrals could be made as necessary. A weekly psycho-social meeting was held where psychological and emotional needs were discussed and relevant referrals made as necessary.

A consultant microbiologist was available 24 hours a day for staff to contact for advice about patients with infections and specific microbiological results. The microbiologist would also visit the ward to offer advice.

**CQC Children and Young People’s Survey 2016 – Q36**
In the CQC Children and Young People’s Survey 2016 the trust scored 8.4 out of ten for the question ‘Did the members of staff caring for your child work well together?’ which is about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Surgical, anaesthetic and paediatric teams liaised well. We observed excellent communication and multidisciplinary working during an emergency situation that occurred during the inspection.

The clinical areas had access to a pharmacist 24 hours a day for advice and guidance. The pharmacist attended the ward regularly to review medicine charts and was available for telephone advice.

The service had service level agreements with mental health services and could access advice and support seven days a week. The department worked closely with the CAMHS team and had access to a psychiatrist for further intervention. There was support from the administration team to ensure all legal elements mental health assessments were in place.

The children’s service had established good links with other specialist children’s services. Medical staff could obtain emergency advice for acutely unwell patients from the relevant on-call tertiary consultant (at a specialist NHS hospital) or by contacting the transport and advice service for the management of critically ill children requiring intensive care in the area.

Transition arrangements for young people moving into adult or third sector services were in place. Multidisciplinary teams worked closely with young people and their families to ensure they were listened to and involved in transition arrangements. For example, adult and paediatric staff saw young people with diabetes or epilepsy jointly for a period before moving to adult services. Staff told us that they would seek advice from the paediatric wards if they were nursing older children on adult wards.

The service had a team of play therapists who worked throughout the trust to support children and young people. All patients and staff we spoke were complementary of work they did to reassure children and young people when they were distressed.
Seven-day services

Bluebell ward, including the paediatric assessment unit (PAU) and the neonatal unit provided seven-day services for children and young people at Lister Hospital. Bramble ward provided five day a week services Monday to Friday 9am-5pm for clinic appointments. This resulted in children having time out from school and parents or carers taking time off from work in order to attend appointments. Surgical on call teams were available at the weekends and seven day emergency operating was available.

Play specialists provided a seven-day service and supported children across the trust. For example, they often supported in the operating theatre recovery area, the X-ray and scanning department and on Bluebell ward.

Paediatricians were available for immediate telephone advice and consultant paediatricians were available and operated a consultant of the week system. Surgeons and anaesthetists provided emergency cover to include children. We were told that surgeons who were on call did not undertake other routine duties. The consultants provided seven day a week cover on Bluebell ward from 8am to 8pm shifts with consultant paediatricians on site between 8:30am-1:30pm and 8pm 10pm, otherwise they were on call from home,

Neonatal consultant cover was from Monday to Friday 8:30am to 5pm with a consultant on site. From 5pm to 8.30 am a consultant was on-call. At weekends consultants were on site for the morning ward round then on call from home. There were on-call arrangements out of hours during the week and weekends.

Interventional radiography (IR) and magnetic resonance imaging (MRI) were not available 24 hours a day, seven days per week. This did not comply with national guidance for seven-day services (NHS: Seven day Services Clinical Standards, 2017) priority clinical standard 6. In an emergency, patients requiring IR or an MRI scan were transferred to other NHS hospitals but there was no formally agreed pathway for the transfer. Data on the number of patients receiving IR and MRI out of hours was not collected by the trust. The service reported no instances of patient harm due to the unavailability of IR and MRI out of hours.

Other diagnostic services for example X-ray, ultrasound and computed tomography (CT) scanning were available 24 hours a day, seven days a week. Staff we spoke with said they accessed them easily. From 9pm to 8am images results were reported off site by an external provider and we were told there was no delay in reporting. Between 8am and 9pm a combination of a separate external company and trust staff reported on imaging. Turnaround during working hours was dependent upon urgency of the request.

Physiotherapy services were provided by another NHS provider and were not routinely available at weekends. Saturday physiotherapy was available for orthopaedic patients only. There was no physiotherapy service on Sundays or bank holidays unless a member of staff volunteered.

Dietitians, occupational therapists and speech and language therapists were not available at weekends for surgical patients.

Pharmacy support was available on the ward Monday to Friday, and out of hour arrangements were in place. The pharmacy service was open from 9am to 5.30pm Monday, Tuesday, Wednesday and Friday, 9.30am -5.30pm on Thursday and 9am to 12pm on Saturday.

Children’s physiotherapy and dietitian services were available Monday to Friday, 9am to 5pm.
The CAMHS team were available to call Monday to Friday between 9am to 9pm and on Saturday and Sunday mornings. Out of hours an on call psychiatrist would cover any queries.

**Health promotion**

We saw that there were some child friendly health promotion displays in the link corridor between Bramble and Bluebell ward for example demonstrating the importance of tooth brushing, however there was also a vending machine selling sweets and sugary drinks in the corridor. There were no healthy food options easily available. We saw noticeboards with patient information in the corridor, however there was limited health promotion information available.

“What's worrying you posters” mental health signs were displayed in the toilets and on the corridor walls to provide information as to how to seek advice for any mental health issues.

The neonatal unit had a designated infant feeding room, which contained information leaflets promoting breastfeeding and expressing breast milk. Support was available for lactating mothers to encourage them to continue breastfeeding for the health of the baby and the health benefits for the mother. However, parents told us that they were not always offered meals whilst they were visiting the hospital which would support their nutritional intake.

All staff were offered the influenza (flu) vaccination to reduce the risk of contracting flu. The final uptake figure for the flu vaccination campaign 2017/18 in children's services was 55.8%. The final total uptake for the trust was 70.5%. This meant that those staff who did not take up the vaccination may have been at an increased risk of contracting influenza over the winter months and being unavailable for work. During the flu vaccination campaign, the health at work service attended children’s services daily to offer the vaccine to staff. there was also a flu champion within children's emergency department.

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

*Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.*

Most staff that we spoke to understood their roles and responsibilities under the mental health act and had an effective understanding of gaining consent from children and young people, and the guidance around this. Staff were able to explain the principles of the Gillick competency and Fraser guidelines which are used to make decisions about the ability of a young person to consent to procedures. The Gillick competency and Fraser guideline help to balance children’s rights and wishes with the hospital’s responsibility to keep children safe from harm. Gillick competence is concerned with determining a child’s capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Nursing staff gained verbal consent before undertaking interventions such as taking clinical observations or giving medication. The parents we spoke with confirmed that staff explained what they were going to do and asked for verbal consent whenever they were present.
There was a consent policy to examination and treatment which covered children and young people and a neonatal care consent policy. The children and young people policy was due to be reviewed in February 2018. We saw that written consent forms used for certain medical and surgical procedures included an explanation of any risks to the child from receiving treatment and we saw examples of these in the seven patient’s notes we reviewed. However, not all risks had been identified in one set of records.

The trust carried out a retrospective audit of consent in July 2017, which looked at 31 patient records across the whole trust, this included all patients. Results showed four sets of patient notes did not contain a consent form; two of these were from surgical specialities (ENT). The consent form was signed by the patients in only 85% of the 31 cases that we looked at and signed by the healthcare practitioner in only 37% of the cases looked at. Only 7% of patients received an information leaflet about their operation and only 10% of patients were given follow up contact details. This was not in line with the trust’s’ consent procedure. Findings from the audit were due to be presented at the rolling half day audit and governance meeting in April 2018 and a further audit was agreed for the future.

We saw that mental health assessments were completed accurately and any additional assessments required were arranged appropriately. Staff described how they would support patients to make best interest decisions if they were over 16 and lacked capacity. Patients in this age group would be encouraged to involve their families or carers in decisions about consent. Ward staff received support from the mental health administration team to ensure that all documentation was legally accurate. We saw evidence of this in the records that we checked. We observed that all the correct procedures, assessments and additional mental health support had been obtained for a patient who was detained under the mental health act.

**Mental Capacity Act and Deprivation of Liberty training completion**

Some staff had completed mental capacity act training and this was now part of the safeguarding training. Staff we spoke with had limited understanding of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DOLS). This was also noted at the previous inspection in October 2015, where there was limited understanding by staff of Mental Capacity Act and Deprivation of Liberty. Overall compliance of staff who had completed level two and level three safeguarding and therefore had also received MCA and DOLS training was 89%.

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 – Effective data**

The trust performed better than other trusts for one question, worse than other trusts for one question and about the same as other trusts for the remaining four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.25</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.60</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.95</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.44</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>8.54</td>
<td>Better than other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>2.72</td>
<td>Worse than other trusts</td>
<td>E4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients and parents confirmed that staff treated them well and with kindness. Staff respected patients privacy and dignity.

All the staff we spoke to were passionate about their roles and dedicated to providing the best possible care to their patients and their families. We observed staff treating and caring for children, young people and their parents kindly and considerately. Nursing and medical staff regularly checked on children, young people and their parents to provide them with the support and care that they needed. Call bells were answered promptly to meet all patients’ needs. Staff respected patients’ privacy and dignity; we observed curtains being pulled around the bed-spaces when patients needed to have care needs met or so that sensitive conversations could be held. Separate rooms were available within the departments to enable privacy and dignity to be maintained. For example, quiet rooms were available for breastfeeding mothers and or discussions with patients about treatment.

Most parents and patients that we spoke to were positive and exceptionally happy about the care that they had received. One parent told us: “They are absolutely brilliant” whilst another told us that all the staff had been friendly and helpful. Parents told us that they felt that their child was safe when left alone on the ward and another felt her baby was safe when she went home at night. However, one parent told us that they did not want to leave the bedside for long periods. Staff communicated skilfully with children, young people and their parents to provide information and explanations about care and treatment that was helpful and appropriate. Parents told us that they had been regularly updated with information.
We observed play specialists supporting children throughout the department. They escorted children to theatre and stayed with them pre and post operatively to reduce their anxiety. We saw a play specialist skilfully supporting a distressed child to have observations taken. Patients with long term conditions were supported by play specialists and many had developed close relationships with them as they had been admitted to hospital frequently. A registered nurse in the day surgery unit explained how she would reassure an anxious child.

Parents we spoke to in the neonatal unit described the staff as helpful and kind. Parents told us that they were kept informed and were able to ask questions about their child’s care and treatment. They told us they were encouraged and guided in providing care for their babies and were supported with breastfeeding and expressing breast milk. One parent described staff taking the time to sit down with her to support her breastfeeding. We saw that parent’s emotional needs were met, staff took time to explore and discuss parental concerns with them and provide individual support.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for one question and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.68</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.66</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.96</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.81</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.73</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.94</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>4.64</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.32</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Do you feel that the people looking after you were friendly?
- 8-15 CYP: 9.45
- About the same as other trusts: C1

Overall, how well do you think you were looked after in hospital?
- 8-15 CYP: 9.01
- About the same as other trusts: C1

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The trust actively sought feedback through the friends and family test. The friends and family test (FFT) for January 2018 for Bluebell and Bramble wards identified that 90% of patients would recommend the service to their friends and family. This was based on 53 responses. 0% would not recommend the service. In February 2018, 85% of respondents would recommend the service for Bluebell and Bramble wards and 100% would recommend the NNU.

**Emotional support**

**Staff provided emotional support to patients and parents to minimise their distress. Staff worked closely with the crisis team to support patients with emotional needs.**

Children and young people experiencing mental distress were able to access the CAMHs (Child and Adolescent Mental Health) services. We observed staff working closely with the crisis team to support patients with emotional needs. We saw that appropriate referrals were in place to meet the needs of patients. There was no psychologist attached to the ward at the time of our inspection but staff assured us that a psychologist could be accessed through the referral process.

The trust provided spiritual care for children, young people and their families as needed. For example, a chaplaincy service was available seven days a week. Staff directed children, young people and their families to appropriate support groups. For example, there was a weekly support group held on the neonatal unit to provide advice on a range of topics, support around traumatic births and information about local children’s centres.

Staff took time to explain procedures and to allow children and their parents to ask questions. We observed child centred care. For example, we saw a child having their surgery clearly explained to them by nurses and doctors. The patient was entertained by play specialists whilst waiting for surgery and felt safe and secure. Staff clearly explained if there were any delays. We were told that some children were taken to the theatre suite when they attended for their pre-operative assessment to help to reduce their anxiety.

We saw play therapists provide good support to children and young people throughout the department. Staff of all grades spoke very highly of the emotional support and skilled interventions of the play therapists in minimising patients’ distress.

Parents on the NNU told us that their emotional wellbeing was considered and support was available for them. An outreach team supported families with babies requiring additional support both before and after discharge.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for all five questions relating to emotional
support in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, emotional support, East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.83</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.24</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.08</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>8.82</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.74</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

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

Staff involved patients and those close to them in decisions about their care and treatment.

Most children, young people and their families told us they were involved in making decisions about their care and treatment. Children between the ages of sixteen and eighteen were given the choice of being cared for on adult or children’s ward. Older children were given the opportunity to speak to a health professional without their parents present.

We observed a child and their parents being fully involved in the development of their care plan. However, we also saw that some patients with mental health needs had not been involved in the development of their care plan.

Staff used appropriate language to communicate with children. We saw that staff had applied a bandage to a child’s teddy bear which was similar to the child’s plaster cast. Another child was shown a piece of equipment that would be used in their surgery, was able to ask questions and was reassured about the process.

We were told that parents in the neonatal unit were involved in providing their babies care, for example changing clothes, nappies and tube feeding. Staff sought consent before providing care. However, one parent in the neonatal unit did not think that all staff could answer her questions properly. Other parents said they were not always informed about their babies’ care but were updated when they asked. Parents could be present on the unit all day but were asked to leave on ward rounds when other babies were discussed.
Parents could accompany their child to the anaesthetic room before their operation and greet their child in the recovery area after their surgery. This helped to alleviate distress and anxiety to the child. Play specialists also supported younger children to and from theatre.

**CQC Children and Young People’s Survey 2016**

The trust performed worse than other trusts for one question, about the same as other trusts for 19 questions and there was no data for the remaining question relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, East and North Hertfordshire NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.84</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.72</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.83</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.02</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.43</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>7.94</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.62</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.51</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.49</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.95</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>7.80</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>
Do you feel that the people looking after your child listened to you?

- 0-7 adults: 8.44

Did hospital staff talk with you about how they were going to care for you?

- 8-15 CYP: 9.02

When the hospital staff spoke with you, did you understand what they said?

- 8-15 CYP: 8.21

Did you feel able to ask staff questions?

- 8-15 CYP: 9.03

Did the hospital staff answer your questions?

- 8-15 CYP: 9.54

Were you involved in decisions about your care and treatment?

- 8-15 CYP: 5.82

If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?

- 12-15 CYP: No Score

Before the operations or procedures, did hospital staff explain to you what would be done?

- 8-15 CYP: 9.19

Afterwards, did staff explain to you how the operations or procedures had gone?

- 8-15 CYP: 8.83

When you left hospital, did you know what was going to happen next with your care?

- 8-15 CYP: 7.10

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Bluebell ward had separate bays where younger children could be cared for with their parents or that could be used as barrier nursing rooms for patients requiring isolation. Staff told us that they would move children and young people to the most appropriate area on the ward if possible, for example we were told that children were moved into different bed spaces if they were being kept awake by crying babies. We saw that this had happened. On the neonatal unit there were two single and two double “rooming in rooms” for parents to be able to stay overnight with their babies. This helped parents to stay with sick children and enabled mothers to establish breast feeding and provide care before being discharged. A kitchen was available in both areas for parents to make drinks, however there were no facilities to heat up food in the neonatal unit and there was no toaster for parents to use on Bluebell ward.

There was a large playroom that connected Bluebell and Bramble wards. All of the toys had been chosen by the children. There was a wide range of toys for all age groups. A separate room was
available for adolescents with sofas and a television. There was another room specifically reserved for oncology patients. An outside play area was available for use during good weather. There was also a play area available for children in the day surgery unit.

The Bramble suite which was used to examine and interview children and young people following alleged abuse was private and child friendly. Bramble ward held a variety of clinics for example there was a jaundice clinic for young babies. GP’s midwives and health visitors could refer into the clinic. Day care was provided for oncology patients, this care was provided one day a week with the unit closed to other patients. The unit was cleaned before oncology patients arrived. This reduced the risk of cross infection. The area contained a variety of age appropriate toys, books and DVD’s. Children and young people were able to access drinks and snacks whenever they wished. Bramble ward was only open Monday to Friday from 9am to 5pm therefore children had to take time away from school for their appointments.

The service worked closely with community services for children and young people for example those with a learning disability. Learning disability nurses were available for advice and support. Play specialists supported children, young people and their families through all aspects of their hospital stay, supported them when they were anxious and worked closely with children who attended the service frequently. All staff we spoke to were complimentary about the work they undertook. We saw how they provided additional support to children and would accompany them to various departments for example X-ray or theatre. There was also a specialist burns nurse within Bramble ward to provide specific care for children admitted with burns. The service had a mental health link nurse on Bluebell ward and a care plan had been developed for children and young people with mental health issues, however there was no involvement with children and young people or their parents around the care planning. However, we did see that children, young people and their families were involved in care planning and treatment on ward rounds and consultations.

Formal transition processes were in place to enable a well-planned transitional process for young people with long-term health conditions as they moved from child-centred to adult-orientated services. This included patients with diabetes, epilepsy and cancers. The trust had a transition policy for children transferring from paediatric to adult services. The transition process began from the first clinic appointment after the patient’s 14th birthday and followed a transition pathway. The patient and family moved over the next two years from a situation where the parent was in charge of the patient’s care, to one in which the patient was competent and confident to be supported by their parent but to be in charge of their own care. It was expected that at their 16th birthday, the young person would be ready to transfer to adult services. There was a specialist policy for children and young people with diabetes and a check list that they needed to complete to ensure their full understanding of their condition. Before transfer to adult services, the young people should be able to demonstrate competency in diabetes knowledge, self-management skills and participate actively in health care decisions. A specialist NHS England children’s cancer network and teenage and young adults network transition policy was also used. The epilepsy service provided a leaflet fully explaining the transition process from paediatric epilepsy to adult neurology services.

The children’s service also held joint clinics with adult services for young people who were in the transition pathway, for example, there were joint clinics for epilepsy and oncology.
Patients aged 16 to 18 years old were offered the opportunity to be treated on an adult ward if they preferred, however, there was no oversight from the paediatric ward when young people under the age of 18 were admitted to wards outside of the paediatric service. Staff from the adult wards would contact Bluebell ward for advice but there was no formal process in place. The trust told us that children and young people were seen in various clinical settings that were outside of the trust’s identified children’s services. However, these were outpatient settings and no under 16 year olds were cared for on adult wards as inpatients.

Services were in place to support the needs of children and young people with mental health issues, learning disabilities or autism. Staff were aware of how to access support from specialist teams and could describe how they would support patients with additional needs.

The neonatal unit had an outreach service which provided care for babies and support for parents before discharge and after they had gone home. The service was commissioned until babies were 44 weeks and six days old. However, the service did not record their outcomes and also had some difficulty with cross border working, communication with community teams and transfer of care. This meant that some vulnerable babies may not receive the care they needed following discharge from the outreach service or that they would remain under the care of the service for longer.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for all 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, East and North Hertfordshire NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.68</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.82</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.39</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>4.78</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.05</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>8.51</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.54</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
</tbody>
</table>
Did your child like the hospital food provided? 0-7 adults 5.31 About the same as other trusts R2
Did a staff member give you advice about caring for your child after you went home? 0-15 adults 8.39 About the same as other trusts R2
Did a member of staff tell you who to talk to if you were worried about your child when you got home? 0-7 adults 8.29 About the same as other trusts R2
Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you? 0-15 adults 7.68 About the same as other trusts R2
Were there enough things for you to do in the hospital? 8-15 CYP 6.71 About the same as other trusts R2
Did you like the hospital food? 8-15 CYP 6.53 About the same as other trusts R2
Did a member of staff tell you who to talk to if you were worried about anything when you got home? 8-15 CYP 7.49 About the same as other trusts R2
Did a member of staff give you advice on how to look after yourself after you went home? 8-15 CYP 8.66 About the same as other trusts R2
Did the hospital give you a choice of admission dates? 0-7 adults 4.12 About the same as other trusts R3
Did the hospital change your child’s admission date at all? 0-7 adults 8.93 About the same as other trusts R3

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Meeting people’s individual needs

The service took account of patient’s individual needs.

Staff throughout the service welcomed parent’s intervention and involvement in their child’s care. On the neonatal unit we saw that parents were encouraged to provide care for their babies and were supported to do so. For example, parents were encouraged to change their babies and to tube feed them. On Bluebell ward we saw a good understanding of meeting parental concerns, for example delaying discharge until after school so that siblings could be cared for.

Parents were able to stay with their children on the ward and there were facilities for some parents to stay overnight. We observed excellent communication on the ward round on Bluebell ward with the child’s opinion and questions sought. Staff told us that they would move patients within the ward where possible if young babies were crying to enable older children to rest. Meal times were protected to enable children to have quieter periods of time on the ward to eat and to rest.

One respondent in the “Learning from Experience” questionnaire for February 2018 said that the menu was repetitive after a week in hospital and their child refused to eat as they were bored with
the meals. Following feedback from parents a new menu was trialled and the service was developing a new menu to provide more variety.

The service provided hot meals for children and young people. Meal times were protected between the hours or 8am- 9am and 11.30am-12.30pm to enable patients to rest and to accommodate a quiet environment during these hours. Children and young people told us that they enjoyed the food and had a variety of traditional and healthy options drinks and snacks were freely available. There was a vending machine selling drinks and sweets in the link corridor between Bluebell and Bramble wards and a mobile sweetshop trolley was seen on Bluebell ward.

A kitchen was available for parents on Bluebell ward so that they were able to make hot drinks.

There were suitable bathroom facilities for patients with a physical disability and adequate space on Bramble ward to accommodate wheelchair users. However, there were no small toilets suitable for younger children in either Bluebell or Bramble ward.

The ward had a dedicated sensory room, which was used for calming anxious children or children with visual impairment.

In October 2016 a new youth forum was established for the Lister hospital Lister Young Voices – these committed and engaged young members are already making a big difference to our patient experience. They organised and hosted a Christmas party for children and young people on Bluebell ward and they have commissioned and co-designed a film to persuade young people that “coming into hospital is not so bad!”

In the Bramble ward there were specific clinics, for example for dermatology and haematology. There was a specialist suite for the examination of children suspected of being subject to abuse. Child protection staff were available when children attended this clinic. A jaundice clinic was held for babies, referrals were taken directly from health visitors and GP’s to enable quick access to services.

In the neonatal unit there were four rooms, two of which were doubles available for parents to stay overnight to “room in” with their babies. This meant that parents could be supported in the care they were providing to their babies before they were discharged home. Breastfeeding mothers were provided with support from the infant feeding coordinator and ward staff to breast feed and to express breast milk.

Parents were offered drinks on the neonatal unit. However, some parents told us that they were not given hot meals when visiting their babies in the neonatal unit. Some of these mothers were breastfeeding or providing EBM for their babies. Breastfeeding mothers require adequate fluid and nutrition.

There was a parent’s sitting room and kitchen for parents to use on the neonatal unit.

The neonatal service had an outreach team who supported families with babies with additional needs and provided home visiting services after discharge for a limited time. However, we were told that there were some difficulties with cross border working and liaison with the paediatric nursing service. Staff sometimes experienced difficulties with some community teams taking over the care of these babies. The outreach team told us that some paediatric nursing teams would not take on the care of the babies they were discharging as they did not meet their caseload criteria. This meant that some babies may have been at risk of not having appropriate ongoing support.
This concern had not been raised with senior staff and was not on the risk register. We could not be assured that the discharge criteria was always being met appropriately.

The neonatal unit had an “under ones” co-ordinator and linked with a local children’s centre. Meetings were held once a week on the neonatal unit to provide first aid training, breastfeeding support, baby massage and financial advice and support. The aim of this group was to support parents with infants who were due to be discharged and provide them with community links.

On the neonatal unit there were small rooms available for staff to have private conversations with families. This was more limited on Bluebell ward where space was restricted; various rooms were available on Bramble ward. There were several well-appointed and child friendly rooms available in the Bramble suite to allow for sensitive conversations to be held.

We saw that there were leaflets and information available for patients and their families. This included information about for example croup, appendicitis, abdominal pain, febrile convulsions and head injuries. However, many of these leaflets were out of date. None of the leaflets were available in other languages; however, staff told us that these could be accessed through the intranet. The trust provided translation services for people who needed assistance speaking to staff in their own language and who would not be able to understand their treatment without this. Services are available for those who do not speak or read English or who were deaf, deaf-blind or hard of hearing. Staff were able to book the services as required.

Mental health services were available and there was a service level agreement with CAMHS services. We saw that appropriate assessments were undertaken as necessary to ensure that the most appropriate care was provided for children and young people. A care plan for “safe care of children and young people in emotional crisis” had been developed but it did not include any emotional support that the patient may require nor was it discussed with patients or relatives. There was a “specialling” team of support workers in the hospital who could provide one to one care for children and young people if they needed additional support or supervision. Play therapists were also available seven days a week and would accompany children and young people to other departments as well as occupy them on the ward and assist them whilst they had procedures for example having an intravenous infusion commenced.

An on-call chaplaincy service was available across the trust. Staff were able to contact the chaplaincy service for both urgent and non-urgent referrals. There were multi-faith services available within the trust.

There was no dedicated schools service within the hospital. Children’s and young people’s services did not provide in hospital educational services as the majority of patients had an average length of stay of under three days. If a patient of school age had a planned or emergency extended length of stay that required educational input, staff would contact the child’s educational organisation via the family or carer and ensure that school work was provided. Staff confirmed that they would contact a child’s school for school work to be provided if they were in hospital for extended periods of time.

**Access and flow**

People could not always access the service when they needed it. Waiting times for treatment did not always meet national standards.
Neonatal Critical Care Bed Occupancy
This information was requested after the inspection but did not break down information into neonatal critical care bed occupancy.

Patients were admitted to the paediatric service through the children’s assessment unit (CAU) and GP referral. The CAU was open 24 hours a day seven days a week. The average length of stay was measured. Between January 2018 and March 2018 across all children and young people’s services the average length of stay was between one and two days.

There was also a rapid access clinic to see a consultant for an appointment that was urgent but not an emergency. We were told that this ran every fortnight and was consultant led. However, GP’s had access to consultants for discussion and treatment planning through a dedicated telephone hot line. This was a Monday to Friday service. If children needed to be seen urgently they were seen in CAU the same day.

Staff told us that there was no reporting of blood cultures after 10pm at night. This meant that some patients were having to stay overnight unnecessarily.

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment time (RTT). All NHS acute hospitals are required to submit performance data to NHS England, who then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter.

A new data management system was introduced in September 2017. We were told that this had not had an impact on patient care. However, following the introduction of the system the service was unable to provide RTT data. No data had been submitted since September 2017. Staff told us that there were some outpatients who had been waiting at least one year for an appointment. Consultant initiative clinics had been introduced and a locum consultant had been employed to address the backlog. A recovery plan developed September 2017 could not be implemented due to the new data management system being introduced. The recovery plan had been revised and implemented.

Neonates were admitted to the neonatal unit via maternity as a planned or emergency admission. Transfers from other hospitals were also accepted as well as some neonates who had returned from the community. There was an escalation policy in place in case of times of peak activity. Staff would access bank staff and all attempts would be made not to close the unit.

Learning from complaints and concerns
Concerns and complaints were treated seriously, investigated and lessons were learned from the results which were shared with all staff. However, complaints were not always managed in a timely manner.

Summary of complaints
From November 2016 to November 2017 there were five complaints about children’s services. The trust took an average of 75 days to investigate and close complaints, this is not in line with
their complaints policy, which states complaints should be resolved within 30 days.

All complaints were linked to the Bluebell ward of Lister hospital, with treatment received being the primary complaint.

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

Information was displayed on notice boards explaining to children, young people and their families how to make a complaint. Leaflets were available detailing how to make a complaint and information was available about the patient advice and liaison service (PALS) service. Information was also available on the trust website.

We saw the “Friends and Family” test was implemented. Most areas had child friendly forms to complete and secure closed boxes were available for completed forms. There was a comment box for suggestions about the service. In January 90% of respondents would recommend the service to their friends and family.

The matron told us that she was involved in investigating local complaints. Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to PALS. Learning from formal complaints and discussion of themes were shared at staff handovers and in team meetings. Themes were identified as concerns about care and treatment. However, we were told that meetings on Bluebell ward were not formally minuted so we were unable to confirm this.

We reviewed ward meeting minutes and saw that complaints, learning from complaints and actions taken were discussed at team meetings on the neonatal unit. Staff told us that communication was the biggest theme. Staff told us that they would initially discuss any concerns with the family to resolve any issues and would provide a written response.

We saw that the trust displayed “You said we did” posters on the information boards outside wards which included complaint outcomes and highlighted any changes made in response to complaints. For example, we saw that visiting hours had been changed and protected mealtimes introduced in response to a complaint. Since 1st April 2018 Bluebell ward had received 72 compliments and 2 complaints.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing sustainable care. Staff felt supported by their managers.

The leaders of the children’s and young people’s service were a divisional chair, a divisional director who was a paediatrician, a head of nursing director, a head of midwifery director, the matron and a non-executive director. The children’s service was part of the women’s and children’s division and there was a clear management structure and defined lines of responsibility and accountability. The children’s and young people’s services included inpatient and outpatients services.
Nursing staff on the wards reported to the ward manager, who in turn reported to the matron for paediatric inpatients or the neonatal matron. These staff reported to the head of nursing for children and young people who represented the department at board level. The assistant director of nursing stated that the multidisciplinary team working in paediatrics was excellent. We were told that band seven nurses were confident in their leadership and would challenge consultants.

All staff spoke very positively about the matrons and the ward sisters. There was a well-established matron in the neonatal unit and a new matron for the children and young people’s division. There was a new ward manager for Bramble ward. Staff described them as supportive and approachable. The matron and ward managers had dedicated time for management duties, however they all reported that they would work clinically if the area was particularly busy or short staffed.

Staff told us that they felt supported by management and that the executive team were visible and approachable. However, we were told that the non-executive director did not visit the neonatal unit frequently. At the last inspection the nursing staff vacancy rate was 30-40%, it had been reduced to 10%. Staff we spoke to told us that they enjoyed working within the department and were given opportunities to develop which included leadership and professional development courses.

The trust had plans to develop a training programme for divisional leadership teams to ensure they have the capabilities to lead their services areas and functions and to ensure consistency of implementation of the new divisional governance framework once this has been developed. This was in its infancy and was to be reviewed.

Vision and strategy

Although there was a vision and strategy for children and young people’s services in place at the time of our inspection, not all staff we spoke with were aware of it.

The service had developed a strategy in an open session in 2016. This was monitored through the children’s board meetings where they have regularly held people to account for actions and implementation of changes. For example, the development of a GP hotline and a network agreement for the early repatriation of babies to the neonatal service. Not all staff we spoke with during the inspection were aware of this local strategy or the actions being taken to achieve it.

The trust had a vision for what it wanted to achieve and plans to turn it into action, developed with involvement from some staff, patients, and key groups representing the local community. Some clinical staff we spoke with were aware of the trust vision and strategy but said they had not been involved in its development. Not all leaders were held to account for the delivery of the strategy or vision.

We were told that the values for the service were the same as the trust values. Staff wanted to provide the best care possible for children and young people and worked as a team. A recent merger with smaller hospitals was improving neonatal care as resources were shared, there was enhanced team working and a better environment for staff which improved the quality of care and safety. This had enabled a dedicated consultant to be available and had improved training opportunities for staff.
Culture

Local management at matron and ward manager level promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Most staff we spoke to of all grades told us that they were proud of the team working culture and that there was an excellent team spirit throughout the department. Medical staff were highly complementary of the “excellent paediatric nurses who improved outcomes for children”. The play specialists were highly praised by all denominations of staff. One staff nurse told us that there were very positive staff who worked hard to ensure that patient safety was paramount.

Junior medical and nursing staff felt well supported, respected and valued by their managers and consultants. We observed positive interactions and working relationships between medical and nursing staff. Staff told us that they had not experienced or observed any bullying at the trust.

Many staff told us how proud they were of the service and the staff who worked within it. Staff told us that they received thank you letters from other units.

Senior staff told us that they had tried to change the culture over the years and have a multidisciplinary vision which they feel they systematically deliver and hold people accountable. Away days had been planned to set the vision for the next two years.

The trust had appointed a freedom to speak up guardian (FSUG) who had been in post for a year. However, few staff were aware of the freedom to speak up guardian or how to contact them. No staff we spoke to knew the name of the FSUG.

Governance

Governance processes were established. There was engagement and involvement of staff at an operational level in governance processes.

There were clear lines of accountability including clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line. The service had a governance structure which included consultants, and matrons. There were effective processes and systems of accountability. Staff were clear about their roles and what they were accountable for.

There was a non-executive director (NED) for children’s and young people’s service. Staff told us that the NED visited Bluebell and Bramble wards but was less visible in the NNU. The NED attended various meetings including safe staffing, clinical effectiveness, quality improvement, patient experience, the charities committee and board meetings.

Monthly divisional board meetings were held. We reviewed minutes and saw that incidents were reviewed, safeguarding issues were reported at board level and new policies were identified, for example the new chaperone policy had been ratified and launched. We saw that staffing including vacancy and sickness levels, appraisals and mandatory training were reviewed. RTT times were discussed. This included 137 children waiting over 52 weeks for appointments.

Monthly clinical governance meetings were held, minutes of these meetings and new guidelines were circulated to staff. We reviewed the minutes of this meeting which corroborated the information provided. Most staff were aware of these meetings and there was involvement from trainee doctors in the updating and development of guidelines. We were told that alerts were
received by the governance group two months before clinical guidelines expired. Nursing staff were also involved in the development of evidence based pathways, guidelines and standard operating procedures.

The trust had reported general financial challenges but staff denied that this impacted negatively on patient care. However, we were told that there was no rolling programme or financial input to support equipment change in the neonatal unit as it got older. This was identified as an area of concern. Risk management meetings were held in the neonatal unit where incidents were discussed. This meeting reported into the children’s board. Staffing levels including staff development and training was discussed and there was an incident review process in place. We were told that the process was facilitated by a multidisciplinary team including a consultant, senior nurse and governance leads. This linked with the trust governance meetings.

The CYP department had had several peer reviews including the neonatal and paediatric oncology service reviews. Positive feedback had been received. For example, the neonatal peer review identified that “the neonatal unit had a cohesive team with inclusive leadership and a strong sense of teamwork.”

**Management of risk, issues and performance**

*Systems for identifying risks, planning to eliminate or reduce them were not always effective. Risks identified during the inspection which were known to the service had not been added to the risk register.*

The service had a risk register in place that detailed the risks to the service, actions to mitigate risks, a risk level, a risk owner and a review date. There were eight risks on the risk register including the risk of inadequate nurse staffing levels in the neonatal unit and patients lost to follow up following the implementation of the electronic data management system. This meant that some children had not been seen in a timely manner and the target RTT times had not been met. Action plans were in place to mitigate the risk and the trust recognised that children were potentially put at risk of harm. The trust had plans in place to arrange for these children to be seen. For example, a locum consultant had been employed but we were not assured that children had not come to harm. There was no time scale on the risk register for the length of time the locum consultant would be employed.

Additional risks that had not been added to the risk register included a backlog of discharge letters and the security doors to Bramble ward being open into the corridor enabling a child to potentially leave the ward area. We identified further risks which had not been added to the risk register during our inspection which included doors into a clinical room on Bluebell ward having access to the road if the door was not closed. There were no keypad locks to the doors to prevent children potentially entering the room. The service addressed this when concerns were raised with them.

A clinical governance group meeting was held monthly to review and develop CYP clinical guidelines. Trainee doctors had the opportunity to participate in this. However, some guidelines were out of date but there was a system in progress to address. The neonatal unit participated in the development of guidelines at trust level, locally and through the local neonatal network. Staff in all areas had opportunities to participate in the development of guidelines and pathways.
The outreach service delivered from the neonatal unit described difficulties with some community services taking their patients after discharge. Outreach staff told us that there was a risk of some children not having follow ups appropriately. The outreach team did not record their activity or caseload numbers, nor did they access the electronic data management system. None of these issues were identified on the risk register.

Risks were discussed at paediatric and neonatal safety huddles which were held twice a day.

**Information management**

The children’s service did not always collect, analyse, manage and use information well to support all its activities, using secure electronic systems with security safeguards. The new data management system had caused a number of incidents in which patients were lost in the system, data was duplicated and some patients were registered twice under different names.

Staff generally had access to up-to-date, accurate, and comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information. The service used a combination of paper and electronic records. The data management system and hand held electronic data system were introduced into the trust in September 2017.

Following the introduction of the data management system there were incidents of patients being lost in the system and data duplicated for instance some patients were registered twice under different names. Training for the data management system had been implemented but we were told it was insufficient. However, there were inbuilt systems to identify children at risk of child abuse. The hand held electronic data system had improved the reporting of deteriorating patients as senior staff would be alerted to deterioration in patient observations enabling a rapid response to be made. Children and young people with mental health issues could be identified through the electronic records.

Discharge summaries were sent electronically to GP’s after patients were discharge. We were told that 75 discharge summaries were delayed and were taking a long time to complete. This meant that GP’s may not receive information in a timely manner and patient’s ongoing treatment or investigations may be delayed. We were told that clinical care was prioritised over discharge summaries and a new rota trainee doctor had been allocated protected time to complete the discharge summaries. There was no clear system to identify outstanding discharge summaries. We were not assured that of the process for managing outstanding discharge summaries were identified.

Staff were responsible for reporting concerns to ward managers who would report to the matron who would have responsibility to escalate concerns further. Junior doctors would escalate concerns to senior medical staff and consultants. Information would be cascaded to staff at team meetings and safety huddles.

We were told by nurses that performance and quality was discussed at ward meetings. However, paediatric wards did not have regular meetings which included all nursing staff grades. Matrons’ audit results were available electronically. However, nursing staff told us they did not normally have time to look at this information. We observed some information on performance being shared.
During daily huddles on some wards. Matrons’ audit results were available electronically. However, nursing staff told us they did not normally have time to look at this information.

Some information technology systems were used to monitor patient safety and improve patient care. For example, staffing levels and the monitoring of patient observations were recorded electronically.

There were arrangements in place which ensured some data was submitted to external providers as required for example, serious incidents and never events. However, effective arrangements were not always in place to ensure that all staff received feedback about incidents and never events.

**Engagement**

The service engaged with patients and parents to plan and manage appropriate services, and collaborated with partner organisations effectively. However, there were limited opportunities for staff engagement as Bluebell ward did not have regular team meetings.

Patients and relatives were given the opportunity to provide feedback using the NHS Friends and Family Test (FFT). The service used child friendly feedback forms to gauge their perception of the care they received. We saw that these feedback forms were available to patients and relatives in all clinical areas we inspected. We were provided with evidence that issues raised through these forms were acted upon by the service. For example, meal times were protected on Bluebell ward with reduced visiting during these times. Patients and parents could also provide feedback using NHS Choices.

Weekly meetings for parents were held on the neonatal unit by a local children’s centre. This meant that families had access to community support before discharge and for ongoing support once they had been discharged.

The trust had a children’s and young people’s forum where patient views were actively sought. All the toys, equipment and furniture in the children’s playroom, adolescent and oncology rooms had been chosen by the children using the service. Parents and carers views were actively sought and they were encouraged to participate in patient and parent forums.

Staff meetings were held but they were not always regular nor did they all have minutes taken. We saw minutes for meetings in the neonatal unit. On Bluebell and Bramble wards we were told that meetings were infrequent and they did not all have minutes taken. This meant that there were limited opportunities for staff engagement. Medical staff engaged with a primary care educational group and held regular educational meetings. There was currently a Project Mind, this project collaborated with young people to discuss mental health issues.

The trust actively sought volunteers to support patients experience whilst in hospital. They also actively engaged with annual patient-led assessments of the care environment (PLACE). The hospital was assessed by a PLACE team, which included members of the public and Healthwatch Hertfordshire, in five categories, with the quality of the Lister’s food, how people with disabilities are supported and the condition, appearance and maintenance of its buildings.
Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they go wrong, promoting training research and innovation.

The neonatal unit was working to Bliss standards but wanted to work towards achieving UNICEF Level 1 baby friendly status. Baby friendly status supports mothers to breastfeed and help all parents to build a close and loving relationship with their baby irrespective of feeding method.

The neonatal service worked closely with the local neonatal networks to develop care pathways and participate in local and national research.

The service had developed care pathways in response to incidents that had occurred so that care and treatment was improved and patient safety enhanced. For example, an appendicitis pathway had been developed and we saw that his was being used in practice.

The trust’s acute paediatric team had been nominated in the best training unit category in the East of England for this year’s paediatric awards for training achievements. One of the paediatric consultants had won an award for best mentor and the department had been nominated for best training unit. These nominations were affiliated to the university.
Mount Vernon Cancer Centre

Medical care (including older people’s care)

Facts and data about this service

Mount Vernon Cancer Centre (MVCC) is part of East and North Hertfordshire NHS Trust and provides a specialist non-surgical cancer service. It is situated in Hillingdon, Middlesex on a large site owned by Hillingdon NHS Trust and is some 33 miles from East and North Hertfordshire Trust’s main hospital in Stevenage. It serves a wide area of two million people across Hertfordshire, Bedfordshire, Northwest London and parts of the Thames Valley.

The trust’s main catchment is a mixture of urban and rural areas in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in Stevenage, Hatfield, Welwyn Garden City and Cheshunt. Over the past ten years, rates of death from all causes, early deaths from cancer and early deaths from heart disease and stroke have all improved and are generally similar to, or better than, the England average.

There is a management team for the cancer centre, which includes a divisional chair, hospital director and a head of nursing.

There are 22 medical inpatient beds located on one ward in the oldest part of the building at MVCC. The ward cares for patients who require inpatient treatment because they are unwell during or following their radiotherapy or chemotherapy treatment. In addition, some patients were admitted for their treatment if it was particularly arduous, or the patient was frail. Some patients received end of life care on the ward. The ward included a two-bed unit for patients who had undergone iodine therapy and were required to be isolated for a short period of time. The wards had been reconfigured since the last inspection due to safer staffing reviews.

The cancer centre was previously inspected by the Care Quality Commission as a specialist stand-alone unit as part of the comprehensive inspection of East and North Hertfordshire NHS Trust from 20 to 23 October 2015. We inspected five core services, chemotherapy, radiotherapy, medicine, outpatients and end of life care. Medicine was rated as inadequate, although the care given was caring and rated as good.

During the inspection, we checked eleven patients’ medical and nursing notes and spoke with 14 members of staff, seven patients and three relatives.

Is the service safe?

Mandatory Training
The service provided mandatory training in key skills to all staff, however, some staff had not completed it. The completion rate for medical staff based at MVCC was 72%, which was below the trust target of 90%.

There were courses all staff needed to undertake which included health and safety, manual handling, infection prevention control, fire safety, equality and diversity and basic life support (BLS).

The trust set a target of 90% for completion of mandatory training courses. Information provided by the trust prior to inspection showed from April 2017 to October 2017, the mandatory training completion rate for Mount Vernon Cancer Centre (MVCC) nursing staff was 92%. The completion rate for medical staff based at MVCC was 72%.

At the time of inspection we saw evidence the mandatory training completion rate for nursing staff on ward 10 and 11 was 86%, which while this was below trust target, we saw staff not compliant had been booked in to the next available sessions. We were told staff sickness had affected the compliance rates.

Managers and staff told us they were alerted their mandatory training was about to become out of date by their online training record. These were emailed three months prior to the date the training expired prompting them to book refresher training. We saw evidence of staff records, which showed a list of training they had completed. Any training that was due for renewal was amber colour coded.

**Mandatory training completion rates**
The trust set a target for completion of mandatory training of 90%. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

**Medical/Dental Staff**

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>187</td>
<td>252</td>
<td>74.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>187</td>
<td>252</td>
<td>74.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>187</td>
<td>252</td>
<td>74.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>186</td>
<td>252</td>
<td>73.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>150</td>
<td>252</td>
<td>59.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Training Course</td>
<td>Nursing staff trained (YTD)</td>
<td>Eligible nursing staff (YTD)</td>
<td>Completion (YTD)</td>
<td>Trust target</td>
<td>Was the target met?</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>------------------</td>
<td>--------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Non-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 yr</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>576</td>
<td>597</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>574</td>
<td>597</td>
<td>96.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>571</td>
<td>597</td>
<td>95.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>568</td>
<td>595</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>494</td>
<td>544</td>
<td>90.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>507</td>
<td>597</td>
<td>84.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>504</td>
<td>597</td>
<td>84.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>464</td>
<td>597</td>
<td>77.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Mount Vernon Cancer Centre had a mandatory training completion rate for medical staff of 72.4%.

Mount Vernon Cancer Centre had a mandatory training completion rate for nursing staff of 91.6%.

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

Safeguarding

Not all staff had attended safeguarding training. Mount Vernon Cancer Centre had a safeguarding training completion rate for medical staff of 60%, which was below the trust target of 90%.
There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.

The service had a safeguarding policy in place, which reflected relevant legislation and local requirements. Staff could find policies from the intranet and most staff we spoke with understood their responsibilities and said the safeguarding team were supportive and accessible. Safeguarding contacts and flow charts were seen in the ward office.

Each division had a safeguarding lead who reported to the head of safeguarding. The trust board received information about safeguarding incidents, investigation and outcomes on a monthly basis and some staff showed good understanding of it. The safeguarding committee was chaired by the executive lead for safeguarding.

There were no patients aged 17 years or under attending MVCC medical care wards within the last 12 months.

Safeguarding training was mandatory.

**Safeguarding training completion rates**

The trust set a target for completion of mandatory training of 90%. A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

The trust’s overall medical safeguarding training completion rate was 53%.

**Medical/Dental Staff**

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Medical staff trained (YTD)</th>
<th>Eligible medical staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target (%)</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>135</td>
<td>252</td>
<td>53.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>131</td>
<td>247</td>
<td>53.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>131</td>
<td>247</td>
<td>53.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>133</td>
<td>252</td>
<td>52.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing Staff

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>574</td>
<td>597</td>
<td>96.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>559</td>
<td>582</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>570</td>
<td>597</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>554</td>
<td>582</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Mount Vernon Cancer Centre had a safeguarding training completion rate for medical staff of 60.2%.

Mount Vernon Cancer Centre had a safeguarding training completion rate for nursing staff of 95.6%.

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

Cleanliness, infection control and hygiene

Infection risks were well controlled. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

The inpatient facilities we inspected although old were visibly clean and tidy. There were regular cleaning schedules in place. Staff had sufficient access to hand washing facilities and hand sanitisers. At the last inspection in October 2015, we observed that staff were not always washing their hands in line with the World Health Organisation (WHO) guidance, “Five moments for hand hygiene.” At this inspection, we observed staff with arms bare below the elbow and following hand hygiene guidelines. Hand hygiene audits were conducted monthly. Data provided to us showed 99% compliance in hand hygiene audit results December 2017 to March 2018 for the ward.

Nursing staff demonstrated a good understanding of infection prevention and control. Domestic assistants we spoke with were aware of appropriate infection control measures to take in relation to clinical and non-clinical waste. The ward carried a range of personal protection equipment (PPE) such as gloves and aprons. Staff wore adequate PPE and adhered to the trust’s infection control policy. We observed green ‘I am clean’ stickers on all equipment.

All patients we spoke with said the trust’s level of cleanliness and hygiene was of a good standard.

The trust had an infection prevention and control policy in place, which was monitored by the infection prevention group. The infection prevention team provided clinical support for staff. Nursing staff we spoke with told us the ward had a good working relationship with the infection
prevention team. The infection prevention nurses were able to attend as and when required. The team provided training in infection prevention and control for example, providing information to assist staff to develop an understanding of how healthcare associated infections (HCAI) can spread, and their duty of care as a healthcare professional to prevent this.

We found there to be an embedded proactive working culture in monitoring, preventing and dealing with health care associated infections within the inpatients team.

The ward had single rooms that could be used as isolation rooms. These would be used in the event of an infection outbreak. Staff told us visiting would be restricted during any outbreak of infection where this was required, and advice given to relatives, as necessary.

There were monthly audits to check for MRSA blood stream infections and wound infections. There were no reported infections for the ward for the period March 2017 to March 2018.

Across the inpatient area, there was no reported case of *Clostridium difficile* (*C. Difficile*) for the period of March 2017 to March 2018.

There were monthly audits to check for catheter acquired urinary tract infections (CAUTI) as part of the safety thermometer national programme. In the period of September 2017 to March 2018, there was one reported CAUTI on the ward.

**Environment and equipment**

*While the fabric of the building was old and in need of redecoration, it was evident that some effort had been expended to ensure premises and equipment were suitable, within the constraints of the environment. Systems were in place to ensure equipment was well maintained, however, this was not always effective.*

The fabric of the building was old and tired. However, maintenance and use of equipment kept patients safe. We checked the resuscitation trolley for the ward and we found it to be tamper evident sealed we saw evidence its contents were in date. The ward had access to a defibrillator unit, stored next to the resuscitation trolley. We reviewed the records, which were kept to confirm emergency equipment, including resuscitation equipment, was checked every day. We saw that safety checks had taken place with no omissions.

The trust followed medicines and healthcare products regulatory agency (MHRA) guidance on the management of medical devices. Electrical medical equipment had registration (asset) labels and were maintained and serviced in accordance with manufacturer’s recommendations. Most equipment checked had electrical safety testing labels attached showing they had been tested and were safe to use. The labels were observed to be in date. However, we noted two pieces of equipment, a blood pressure machine and an intravenous stand, displayed do not use after dates which had expired. A mobile x-ray unit stored on the ward also did not have an electrical testing label attached.

- A blood pressure machine stored in the alcove by nurses station on female side of the ward (ward 11) displayed a do not use sticker dated 18 March 2018 which was three days post expiry date and was still on ward within easy reach of staff.

- An intravenous stand in stored in a store room along back corridor between the male and female side of the ward displayed a do not use sticker dated 20 March 2018, which was
one day post expiry date and was within easy reach of staff. It had a green ‘cleaned’ sticker attached, which had been completed recently. The expiry date was not escalated following cleaning.

- A mobile x-ray unit stored on the ward also did not have an electrical testing label attached. This meant that the service did not have robust systems in place to ensure that all equipment was serviced and maintained in line with the manufacturer’s instructions and therefore safe to use.

We alerted a member of the senior team to the expiry dates and these pieces of equipment were taken out of action and identified for checking.

We observed a variety of mobility equipment such as walking frames and hoists used and stored within the wards we visited. All mobility equipment was maintained and regularly cleaned. We observed green ‘I am clean’ stickers on all equipment.

Arrangements for managing waste kept people safe. Staff followed guidance for the storage and disposal of waste. Clinic rooms we looked at on the ward were visibly tidy and equipment was stored appropriately. Sharps bins in use at the time of inspection, were checked and all were appropriately labelled and signed.

Suitable equipment was available in line with Royal College of Nursing for the management of pressure ulcers. Patients identified at being at risk of developing pressure ulcers had access to pressure-relieving support surfaces and strategies for example, mattresses and cushions 24 hours a day. Patients assessed as having a grade 1-2 pressure ulcer had provision, to be placed on a high-specification foam mattress or cushion with pressure-reducing properties. Patients assessed as having grade 3-4 pressure ulcers, had provision, to be placed on an alternating pressure mattress or sophisticated continuous low pressure system.

Assessing and responding to patient risk

Patient moves per admission

The trust was not able to provide any information for patient moves. The trust provided the following statement:

“The information requested is currently not available, partly because of the newly implemented systems. Nerve centre is used to allocate beds and every move, if and when it occurs should be recorded on the system. Patients are moved for several reasons, mainly for clinical reasons, such as appropriateness of ward, needing a speciality bed, infection control. Patients who are also outliers on a ward are moved to the most appropriate ward when that becomes available. We monitor this on a daily basis through Operations Centre. As part of our Winter Planning we are implementing revised plans for the safe management of medical outliers in the Trust.”

(Source: Trust Routine Provider Information Request (RPIR) P53 - Ward moves)

Risks to patients who used services were assessed, and their safety was monitored and maintained. However, we could not always find evidence in patients’ records of action taken as a result of nutrition and falls risks, assessments.
Comprehensive risk assessments were carried out. There was a system in place to support the deteriorating patient. National early warning scores systems (NEWS) was used to identify patients whose conditions were at risk of deteriorating. Nursing staff monitored all inpatients on hourly ward rounds and used the NEWS score to identify patients who were deteriorating. Risk management plans were developed in line with national guidance. We saw evidence of staff escalating an unwell patient appropriately to the medical team in patient’s notes and using the NEWS documentation.

We found that all patients had been assessed using national risk assessment tools such as in nutrition, falls risks, manual handling needs, skin integrity and pressure areas with body mapping. We saw evidence that most initial assessments were completed within 24 hours. Assessment compliance was audited as part of the weekly notes audits. We saw appropriate referrals had been made, for example to the palliative care team. However, we could not always find evidence in patients’ records of action taken as a result of these assessments.

Patients were seen and assessed by a relevant consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital, which met London Quality Standards.

Staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and medical emergencies. The ward staff also attended the daily doctors meeting to identify those who were at risk on the ward, raising awareness for staff of those risks and actions to prevent or reduce harm. This was a daily process, which brought the multidisciplinary team together to review all of the patients.

MVCC did not have their own dedicated crash team. However, MVCC had a service level agreement with the acute trust based on the same site, which meant any crash calls were attended by their crash team. MVCC staff also supported the crash team. A crash team is a team of medical practitioners that stand by to resuscitate patients who have suffered cardiac or respiratory failure. Staff told us it took approximately five minutes for crash team to attend the ward. The inpatient wards procedure to handle a deteriorating patient was to stabilise them using the resuscitation equipment and then call 2222. This call would trigger the crash team and a 999 call.

Most staff, 92% of nursing staff and 72% medical staff, were trained in basic life support (BLS) and intermediate life support (ILS) as part of mandatory and statutory training, the procedure to handle a deteriorating patient was to stabilise them using the resuscitation equipment while a call was made using 2222. Nursing staff we spoke with were aware of this and could describe the procedure in detail.

There was a formal pathway for transfer of emergency and urgent patients at MVCC including key contacts related to specific specialities. The pathway document stated if the patient had a condition that required urgent treatment, for example, bleeding, an emergency ambulance was called and patients transferred to an identified neighbouring trust for ongoing acute treatment. Approximately two patients a week were transferred urgently. This was an improvement from the last inspection. At the last inspection, details about patients who had been transferred out were all recorded informally and were not reported via the trust’s incident reporting system. There was no process in place to follow up these patients so the service was not updated on how the patients’ cancer treatment been maintained. Therefore, the trust were unsighted on this risk and no actions had been taken to address this concern. During this inspection, we saw oversight had improved. The trust had introduced an urgent transfer and step up book, this included a protocol and
guidance for staff to follow in the event of a patient requiring transferring out for acute medical care. Staff used this book to document the details of the events leading to transfer and where they had been transferred to. Information recorded was clear, accurate, complete, legible, up to date and signed. The MVCC doctor in charge of the patient's care, followed up the patient via telephone daily. This ensured updates were recorded and monitored. Not all transfers were recorded as incidents, however, the head of nursing at MVCC carried out a monthly audit of the patients transferred out and used this process to look for trends, themes, and any learning points. Audit results and learning information was presented quarterly to the divisional clinical governance committee and at quality improvement board.

There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. The hospital had an acute oncology service (AOS) in line with the recommendations of the National Chemotherapy Advisory Group report (2009). This enabled a rapid response to be given when patients developed symptoms, for example, neutropenic sepsis. Neutropenic sepsis is a life-threatening condition whereby the chemotherapy adversely affects the body’s ability to resist infection by affecting the bone marrow and decreasing white blood cell production. A key indicator of successful access to treatment is access to intravenous antibiotics within one hour for patients who were suspected of having neutropenic sepsis. Between 1 January and 30 March 2018, 15 patients were admitted to the ward with suspected neutropenic sepsis. 100% received antibiotics within an hour.

**Nurse staffing**

*There was enough staff on the ward with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.*

Staffing levels, skill mix and caseloads were planned and reviewed so patients received safe care and treatment at all times, in line with relevant tools and guidance.

The Safer Nursing Care tool (SNC) was used by the trust to calculate staffing requirements across the inpatient services. The SNC tool determined acuity and dependency levels of patients in hospitals; it was used to assess the care needs of patients, estimated care hours and suggested care arrangements. This meant that appropriate skill mix and staffing levels were planned, which met the Royal College of Nursing safe staffing guidance.

The trust had a proactive approach to monitoring its staffing. Ward staff completed the staffing acuity tool daily, which demonstrated planned versus actual staffing levels. This was collated into a monthly report. A monthly report was produced to provide trust board with an analysis of staffing data.

Staffing numbers were discussed with the management team, at a safer staffing meeting twice a day. Staff could be moved from other units to assist. Staff told us where staffing was lower than expected due to sickness the ward manager and matron would work within the staffing numbers.

A board at the ward entrance, showed the number of nursing staff that should be on duty and the actual number. On one of the days of the inspection, we saw that actual staffing did not meet planned staffing numbers, due to a qualified staff member’s sickness. A member of staff from another part of the service was quickly moved to assist with care on the ward. We did not see any
evidence of patient care being compromised by lowered staffing numbers. Ward staff were busy, but call bells were mostly answered in a timely way. There were no incidents reported as a direct result of lower staffing numbers.

On occasions, the ward used bank and agency staff, however ‘regular’ bank and agency staff were used to promote continuity of care and minimise risk. Regular’ bank and agency staff are staff who regularly booked to work on the ward. New agency staff received a short induction to orientate them to the service prior to commencing shift.

**Bank and agency staff usage**

From December 2016 to November 2017, the trust reported the following numbers of usage of bank and agency in medicine:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank/agency</th>
<th>Registered nurse</th>
<th>Proportion of bank or agency on the staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Bank</td>
<td>10558</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>11583</td>
<td>79.8%</td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>5619</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>Bank</td>
<td>628</td>
<td>63.5%</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
<td>866</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not filled</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

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

**Medical staffing**

There were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment.

Doctors we spoke with told us they felt that the service was adequately staffed and the use of locum staff was rare.

Doctors on duty ranged from Foundation doctors (FY1), newly qualified doctors) to specialist trainees, all of whom were attached to a team. Medical staff told us they felt well supported at all levels. Junior staff spoke positively about the support provided by the consultants, both while they were on site and if they needed to be called out of hours. Consultants were available seven days a week. There was good access to training. Medical staff felt very much part of the ward team and were able to describe good multidisciplinary working.

The trust has reported their staffing numbers below for the period March 2017 to October 2017 for medicine.
<table>
<thead>
<tr>
<th>Sum of Planned staff – WTE</th>
<th>Sum of Actual staff – WTE in month</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>240</td>
<td>247</td>
<td>103%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**
From December 2016 to October 2017, the trust reported a vacancy rate of -5.6% in medicine; which meant there were more staff employed than budgeted for.

- Mount Vernon Cancer Centre: -3.5%, which meant there were more staff, employed than budgeted for.

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

**Turnover rates**
From December 2016 to October 2017, the trust reported a vacancy rate of 0.8% in medicine:

- Mount Vernon Cancer Centre: 1.4%

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

**Sickness rates**
From December 2016 to October 2017, the trust reported a sickness rate of 0.8% in medicine;

- Mount Vernon Cancer Centre: 1.4%

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

**Staffing skill mix**
In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the national average.
Staffing skill mix for the 225 whole time equivalent staff working in medicine at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</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 (01/10/2017 - 31/10/2017))

Records

Staff kept records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. We also found limited documented evidence of actions taken following nursing assessment in patient records.

Patient’s individual care records were generally written and managed in a way that kept people safe. The ward used paper records. We checked a total of eleven patients’ medical and nursing notes. These records were clear, accurate, complete, legible, up to date and signed. Admission notes were legibly documented and were in keeping with appropriate national guidance such as general medical council guidance on keeping records, CG2 – Record Keeping Guidelines. The medical and nursing notes contained a main assessment sheet with information such as personal details, details about current diagnosis and past medical history. This was present and fully completed in all sets of notes we checked.

There had been an improvement in the completion of nursing assessments such as skin assessments, pressure ulcer repositioning records, body maps indicating pressure points, national early warning scores (NEWS), malnutrition universal screening tool (MUST) assessments and falls assessments since the inspection in October 2015. However, we found limited evidence of actions, taken following nursing assessment. For example, where falls assessments or nutritional assessments showed a risk, there was not always an appropriate prevention care plan in place.

There was one do not attempt cardiopulmonary resuscitation (DNACPR) form in place, it was completed as per guidelines.

The service securely stored patient records. On the days of inspection, patients’ medical records were stored securely in locked cabinets, in a locked room on the ward and daily nursing notes
were kept at each patient’s bedside. Notes for discharged patients and archived records were stored in locked cupboards in locked rooms. However, we were not assured lockable doors were always locked. We noted that not all staff were able to access the locked rooms on the ward, as they were not aware of the door codes. A staff member was overheard stating, “the door was only locked because the CQC were here”.

The quality of patients’ care records were regularly audited. They were reviewed and monitored by senior staff within the ward who conducted monthly notes compliance audits. The target was 100% compliance. The data provided to us showed that for the period of 1 January 2018 to March 2018 that wards met the compliance target.

Medicines

Medicines were prescribed, given and recorded in line with best practice. Patients received the right medication at the right dose at the right time. However, medicines were not always stored securely.

Staff used medicine trolleys for distributing medicines to patients on the ward. Medicines were not always stored securely in locked trolleys. We found one medicine trolley on the ward left unlocked and unsupervised during a morning medicine round for 15 minutes. This was raised and immediately locked.

Medicines were stored in locked cupboards on the wards. Access to all medicines was controlled by an electronic locking key system. Each staff member was assigned their own key, which granted them access for their shift. Staff told us it not only saved time looking for other key-holders or looking for the right key for the lock. It also removed the security issue when a key was misplaced. The system enabled a lost key to be deleted from the system and there was a record of the last person to have the key so it could be followed up.

Medicines that needed to be kept below a certain temperature were stored in designated refrigerators in clinic rooms. Records confirmed that drug refrigerator temperatures were checked daily and were within recommended ranges. Staff knew what action to take if the temperatures were not within a safe range. There were medicine refrigerator in a locked clinic room on both sides of the ward. However, the lock on the refrigerator in the male side clinic room, which contained chemotherapy drugs, was broken. This meant there was a risk medicines could have been tampered with. Although it had been reported, the staff did not know when the lock would be replaced. We raised this at the time of inspection, and a replacement lock was being sought as a matter of urgency.

Nursing staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council (NMC) standards for medicine.

A medicines round was observed. Patients’ names were checked with their identity bracelet and the charts were signed to indicate that medicines had been taken.

Medical gases were stored appropriately. Staff were trained in safe use and storage of medical gases.

Prescription charts had been reviewed by the pharmacy team in all 11 notes we looked at. All the charts had medicines reconciliation completed and recorded. Medication reconciliation is the
process of creating the most accurate list possible of all medications a patient is taking including
drug name, dosage, frequency, and route and comparing that list against the doctor’s admission,
transfer, and/or discharge orders, with the goal of providing correct medications. Allergies were
recorded in line with National Institute for Health and Care Excellence (NICE) guidance. This
information is important to prevent the potential of an inappropriate medicine being given in error
and causing harm.

Patient’s weight and height were recorded, to determine the correct dose for certain medicines.
The prescription charts were all signed by the prescriber and checked by a pharmacist.

Medicines audits were carried out weekly by the ward based pharmacist. The nurse in charge
reviewed medicines charts daily to check for missed signatures. Any identified trends were
addressed with staff.

We reviewed the controlled drug registers and found there were no stock discrepancies.
Controlled Drugs (CD’s) are medicines, which are subject to additional controls as they are liable
to be misused. We saw that the ordering and delivery systems for CD’s met legal requirements,
the registers were accurately maintained and that CD’s were stored appropriately, with balances
being regularly checked and recorded when administered. Controlled Drugs (CDs) which required
special storage and recording were stored following good guidance procedures including daily
checks by two nurses.

Clinical pharmacy service was available, and the ward had an allocated pharmacist who ensured
stock levels were maintained. They also provided advice regarding medicines management for
both staff and patients.

Arrangements were in place to ensure that medicine related incidents were reported, recorded and
investigated and staff we spoke with knew how to report incidents involving medicines.

Incidents

Staff recognised incidents and reported them appropriately. Managers investigated
incidents and shared lessons learned with the whole team and the wider service. When
things went wrong, staff apologised and gave patients honest information and suitable
support. However, we were not assured that all staff understood their responsibilities in
regard to duty of candour.

Incidents were reported using the trust’s electronic reporting system. Staff were trained how to
identify an incident or a near miss and to use the reporting system. Staff said they were confident
to report incidents. Staff gave examples of incidents they had reported and their outcomes.

Staff told us that depending on the type of incident reported, the head of nursing or ward manager
would receive the incident to investigate. Root cause analysis was done for any incident causing
moderate harm and above. A panel followed up serious incidents; this panel reviewed the actions
and outcomes from any investigation. Staff we spoke with confirmed this was the process.

Staff told us that teams and the organisation as a whole learned from incidents and there was
evidence of clear action planning following reviews. Staff told us feedback to teams was discussed
in team meetings and briefings. However, these meetings were not always minuted, so we were
unable to confirm this. Individual feedback was also given via email to the incident reporter.
At the previous inspection in October 2015, patients were transferred out of the hospital by emergency (999) ambulance if they developed conditions or complications whilst they were receiving treatment for their cancer, for example bleeding or cardiac problems. Looking at records, this happened on average up to twice per week. However, these were not recorded as incidents on the hospital reporting system. There was no trend analysis or evidence of learning. Therefore, it was difficult to ascertain the extent of any patient safety implications. The trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book, which allowed updates to be recorded and monitored. While not all transfers were recorded as incidents, the head of nursing at MVCC carried out a monthly audit of the patients transferred out and used this process to look for trends themes and any learning points. This process met the hospitals policy for patients transferred out.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Some staff explained that if any incident caused harm to a patient, a formal apology would be issued by an appropriate member of staff and the incident was discussed with the patient and family. However, not all staff we spoke with understood their responsibilities in regards to duty of candour. Senior managers were aware of the duty of candour. We saw an apology and discussion was documented in a patient’s healthcare record regarding a serious incident that had occurred a few weeks prior to our inspection. Senior staff had ensured the patient had been fully informed regarding the incident.

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 January 2017 to December 2017, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in medicine, which met the reporting criteria set by NHS England, from January 2017 to December 2017. All of these incidents occurred at Lister Hospital.
There were a total of 148 incidents reported for ward between April 2017 to March 2018. Out of these incidents 109 resulted in no injury, 31 resulted in minimal harm and three resulted in moderate harm, one resulted in severe harm. Three incidents had been reported as serious incidents.

**Safety Thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. They used the information to improve the service.

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 three new pressure ulcers, three falls with harm and seven new catheter urinary tract infections from December 2016.
to December 2017 for medical services.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers</th>
<th>（3）</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Falls</td>
<td>（3）</td>
</tr>
<tr>
<td>Total CUTIs</td>
<td>（7）</td>
</tr>
</tbody>
</table>

(Source: Safety thermometer - Safety Thermometer)

Safety thermometer information was displayed on the ward notice board so it was accessible to patients and visitors.

Each ward had a monthly dashboard that was used to set the targets for safety performance and nurse sensitive indicators, such as compliance with infection control protocols and care associated risk assessments. The dashboards were discussed at governance meetings and team meetings.

The ward had a good record of harm free care. The ward had not had any hospital acquired pressure ulcers for four consecutive years until December 2017 when a patient developed a grade two, hospital acquired pressure ulcer. However, investigations showed this was unavoidable.

### Is the service effective?

**Evidence-based care and treatment**

Care and treatment was delivered based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. However, we did not find evidence of care plans to address the issues flagged by risk assessments.
Relevant policies and professional practice guidelines such as National Institute of Health and Care Excellence (NICE) and Royal College of Nursing policies were used to support the care and treatment for patients. Staff confirmed they could access trust policies via the intranet. Policies we reviewed referenced up to date relevant national guidelines and best practices.

Policies were assessed to ensure guidance did not discriminate on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

Patients were assessed using recognised risk assessment tools. For example, the Waterlow Score, a nationally recognised practice tool was used to assess the risk of developing pressure damage. Staff also undertook falls risk assessments and nutrition assessments. However, we did not always find evidence of care plans to address the issues flagged by the assessments.

Care plans that we did see in use, were prepopulated, with limited ability to address individualised or person centred care needs. Not all notes we reviewed had care plans in place. Without care plans there was a risk the patient's care needs would not be effectively communicated to all staff providing care.

Clinical nurse specialists (CNS) were utilised in some areas to ensure that patients with complex needs were supported. During the October 2015 inspection however, it was reported that clinical nurse specialists were in short supply in some specialities. During this inspection, staff and the trust told us that recruitment had addressed the shortfalls and staff did not report a shortage of CNS.

The ward nursing team used the ‘pepsi cola aide memoir’ (PCAM), a holistic common assessment of supportive and palliative care needs for adults with cancer, which was reproduced and adapted from the gold standard framework toolkit (2004). The PCAM is a tool to support practitioners carrying out assessments and can be used alongside other assessment tools currently in use. It promotes communication and support and provides a framework to consider patients’ holistic needs. In the eleven notes reviewed, four sets of notes the PCAM had not been started. The PCAM was part completed in seven sets of notes. However, the emotional, anxieties, spiritual wellbeing sections were not completed. Social aspects were also missed in all seven sets of notes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Nutrition and hydration assessments were completed for all appropriate patients in the eleven care records reviewed. This was an improvement since the October 2015 inspection, where we found nine sets of care records to be incomplete with regards to nutrition and hydration assessments.

Nursing teams used malnutrition universal screening tool (MUST) assessments. Patients were screened on admission for malnourishment and the dietician assessed all patients whose nutritional needs were highlighted. Patients were weighed on admission and weekly thereafter to ensure nutritional needs were met.

We observed and patients reported that food and fluids were placed within reach.

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Fluid balance charts were completed for patients whose hydration was an identified issue. Patient hydration was monitored during the hourly care rounds and recorded in the patient notes. Food and fluid records we reviewed were complete, accurate and current.

Protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted and meant staff were available to offer assistance were required. Patients told us that the food was of good quality and that they had plenty to eat and drink throughout the day.

Staff had access to advice from dietitians and speech and language therapists (SLT). Dietitians and SLTs visited the ward to speak with patients on request.

**Pain relief**

**Patients’ pain was assessed and managed appropriately.** Patients told us that their pain was adequately controlled. They told us that pain relief was offered and given immediately after it was requested. Pain scores were recorded using a numeric rating scale on the national early warning score (NEWS) record sheet. We saw this was being used correctly.

Medicine administration records indicated when patients could be given further as necessary medicine. This meant that patients could have additional pain relief when it was required. Patients told us they were given pain relief and were comfortable.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The Mount Vernon Cancer Centre had a strong reputation nationally for contribution to national clinical trials. The centre had good recruitment to trials and contributed to improved outcomes through developing new treatment protocols.

The ward participated in the national patient safety thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.

A key indicator of successful access to treatment is access to intravenous antibiotics within one hour for patients who were suspected of having neutropenic sepsis. An audit of all patients (15) with suspected neutropenic sepsis had been carried out between 1 January 2018 and 30 March 2018, it showed 100% had their antibiotics within an hour.

**Relative risk of readmission - Mount Vernon Cancer Centre**

From September 2016 to August 2017, patients at Mount Vernon Cancer Centre had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in Clinical Oncology (Previously Radiotherapy) had a higher than expected risk of readmission for 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 Clinical Oncology (Previously Radiotherapy) had a higher than expected risk of readmission for non-elective admissions

• Patients in Medical Oncology had a lower than expected risk of readmission for non-elective admissions

• Patients in Clinical Haematology had a higher than expected risk of readmission for non-elective admissions

**Elective Admissions - Mount Vernon Cancer Centre**
Readmission rates were noted on the trust’s monthly information performance dashboards and were discussed at divisional senior manager level and at board level. Senior staff at a local level, reviewed patients notes who had required readmission. It was noted in the May 2018 board meeting minutes that the higher than average readmission rates were due to either incorrect recording or reduced length of stay having an impact on patient readmission. The board was of the view that simplifying the pathway would ensure patients were in the right place and sitting with the right teams, limiting readmissions and therefore bring admissions into the green. While continued to be above the national average, readmission rates had shown a gradual decrease from April 2017 and September 2018.

**Non-Elective Admissions - Mount Vernon Cancer Centre**

*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.*
Lung Cancer Audit
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 54%, which was worse than the audit minimum standard of 90% by 36%. The 2015 figure was 92%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 8.3%, this is below the national level of 24% by 15.7%. The 2015 figure was 26%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 63.6%, this is below the national level of 64% by 0.4%. The 2015 figure was 64%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.7%, this is below the national level of 69% by 1.3%. The 2015 figure was 68%.

The one year relative survival rate for the trust in 2016 was 36%.
(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017
The crude proportion of patients who had a vision assessment (if applicable) was 77%. This was below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 41%. This was below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 100%. This met the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 100%. This met the national aspirational standard of 100%.
(Source: Royal College of Physicians)

We saw that performance in national audits was monitored by divisional senior managers and that a gap analysis and an action plan was completed where performance did not compare favourably with the England average. These tools considered performance levels against national outcomes and graded the risk of any underperformance. Recommendations were made in the form of action plans in order to improve performance. Action logs were shared and discussed at divisional governance meetings in an attempt to drive improved performance.
Competent staff

Staff were competent for their roles. Managers appraised most staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, when they took on new responsibilities and on a continual basis.

Managers had oversight of the staff training compliance. Staff confirmed that they had received updates on mandatory training.

Staff were allocated time to complete mandatory or other training along with continuous professional development time. This was scheduled into the area staff rotas.

New staff members underwent a trust induction this was confirmed by new staff. New staff were supernumerary on the ward for the first two weeks, to undertake a local induction. The trust induction policy outlined the requirements for new starters and bank staff, which included corporate and local induction and completion of mandatory training. Staff that recently joined the trust said they had found the induction process successful and informative. They also said they were very satisfied with the level of support they received.

Staff told us they were supported by their managers to attend additional training days and to complete online training to develop their professional and clinical skills, for example administration of chemotherapy. Staff said the training they had received was appropriate and relevant to their work role and ensured they maintained their professional development.

There were systems in place, supported by the human resources department with regards to revalidation and registration with the relevant professional bodies for example nursing and midwifery council (NMC) and general medical council (GMC). Local management had oversite of the registration status of staff they line managed. Staff told us they had been supported with revalidation. Revalidation was introduced by the NMC in April 2016 and was the process that all nurses and midwives must follow every three years to maintain their registration.

Doctors we spoke with felt they had good access to training and could get advice from the consultants as required.

At the previous inspection in October 2015, we found there to be no formal clinical supervision for nursing staff. On this inspection, we saw formal group supervision was available for nursing staff. Staff were expected to attend a session every eight weeks. Staff told us they also had opportunities for informal supervision within their teams on a regular basis.

Appraisal rates

The trust’s appraisal policy stated that all staff were required to have an annual appraisal. Staff said it was a useful process for identifying any training and development needs. From April 2017 to October 2017, 82.7% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%.
A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of appraisals completed – YTD</th>
<th>Number of individuals required for appraisals - YTD</th>
<th>Proportion of staff with appraisals</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>117</td>
<td>138</td>
<td>84.8%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>74</td>
<td>78</td>
<td>94.9%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>53</td>
<td>62</td>
<td>85.5%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>385</td>
<td>474</td>
<td>81.2%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>192</td>
<td>247</td>
<td>77.7%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>854</td>
<td>1033</td>
<td>82.7%</td>
<td>No</td>
</tr>
</tbody>
</table>

Mount Vernon Cancer Centre had an overall appraisal completion rate of 90.3%.
At the time of inspection, we saw the appraisal compliance rate for nursing staff on the ward was 93%.

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

Multidisciplinary working

All staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide effective care.

There were daily full team handovers, including ward nursing staff from the medical staff on night duty to oncoming staff. Multidisciplinary ward rounds were also carried out daily. Staff reported that they worked well with all the multidisciplinary team, including doctors, therapists and social workers.

Relevant professionals were involved in the assessment, planning and delivery of patient care. We observed good working relationships between a range of health professionals, such as occupational therapists and physiotherapists within the trust.
There was open communication between staffing groups. Staff were able to access the patient care records. There was evidence of multidisciplinary team (MDT) working throughout patient notes. Therapists, social workers and specialist palliative care nurses (SPCN) and nursing staff contributed to and shared information on patient care.

Staff had good working relationships with teams at other hospitals when patients were required to attend other hospitals for treatments and investigations. Staff we spoke with found the input of other clinical teams and nurses to be very good. The named nurse would take responsibility for communicating with other clinical teams and this information would be shared with all staff at the daily doctors meetings.

There were pathways for referral between specialities both at the hospital and specialties at the local acute services. For example, there was a formal pathway for transfer of emergency and urgent patients at Mount Vernon Cancer Centre (MVCC), including key contacts related to specific specialities. It stated that if the patient had a condition that required urgent treatment, for example, bleeding, an emergency ambulance was called and patient was transferred to an identified neighbouring trust for ongoing acute treatment. Staff were aware of these pathways.

Seven-day services

Hospital inpatients had timely 24-hour access, seven days a week, to consultant-directed interventions that met the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols. There were lead consultants on the duty rota who were in attendance seven days per week with a specialist trainee.

A ward-based pharmacist was available Monday to Friday to review all medicines and attend the daily multidisciplinary team meetings. There was an on call service for emergencies out of hours.

There was seven-day availability, on call out of normal working hours, of diagnostic services including imaging, emergency radiotherapy and laboratory facilities. Some services had to be accessed off site, by agreement at a local acute trust hospital, for example procedures to insert drains or carry out biopsies under radiological or ultrasound control.

Health promotion

Health promotion information including leaflets regarding stopping smoking, living with dementia and advice on managing symptoms were available for patients and visitors to read.

Access to information

Staff generally had access to the information they needed to deliver effective care and treatment to patients.

Information was available to deliver effective care and treatment to relevant staff in a timely and accessible way. Chemotherapy prescriptions and treatments were in an electronic format, all other documentation was paper.
The do not attempt cardiopulmonary resuscitation (DNACPR) forms were stored at the front of patient’s notes. They were easily identifiable and allowed easy access in an emergency.

Staff told us they generally had good access to patient related information and records whenever required. This meant that staff had access to the information, which enabled them to care for patients appropriately. However, some staff reported there was sometimes a challenge to find the patients records initially at the time of admission as they were in a paper format, particularly if the patient had interacted with several different departments. Staff would track the patients’ pathway and check with each department if the notes were with them. Notes were generally located using this method. We did not see any evidence of patients’ notes not being available for an inpatient stay. This was similar to the findings of the October 2015 inspection.

Handover of patients care to other members of staff within the service were structured and informative. There was a twice daily nursing handover. We observed a morning nursing handover and a doctors meeting. Both were structured. They included a summary of the patient’s condition, their progression with treatment. The doctors’ meeting also included information about risks associated with the patients and how these were being managed, and their specific goals for treatment. Sufficient time was set aside for handover to take place so that all staff were fully up to date with the patients and their treatment plans.

There was easy access via an electronic system, to diagnostic results such as blood results and imaging to support the staff to care safely for patients.

Information including referral, discharge and transfer, was sent to ensure their ongoing care was shared appropriately, in a timely way when patients moved between teams and services.

Key policies, for example infection prevention and control and chemotherapy guidelines were easily accessible on the hospital’s intranet. Staff were able to show us how to obtain this information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had limited understanding about their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to offer support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, staff were not confident in their abilities to carry out a mental capacity assessment.

Staff we spoke with had limited understanding of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS). This was also noted at the previous inspection in October 2015, where there was limited understanding by staff of Mental Capacity Act and Deprivation of Liberty Safeguarding (DOLS) and staff said they had not had any MCA and DoLS training.

On the current inspection 96% of nursing staff and 60% of medical staff based at MVCC had completed training, via e-learning as part of mandatory training. However, nursing staff we spoke with were not confident in their abilities to carry out a MCA assessment, stating it was the medical team who completed these. Staff knew that there were contact phone numbers on boards in the wards areas for the safeguarding leads in the hospital, who would be able to support staff with DoLs applications.
At the time of inspection, staff told us there were no patients on the wards who required a mental capacity assessment. In the eleven notes we reviewed, none contained mental capacity assessments or deprivation of liberties safeguards documentation (DoLS), which was appropriate for the patient group at the time of inspection. Staff reported if they had concerns about a patient’s capacity they would request the consultant to review and carry out any necessary assessments.

The consent policy and hospital consent forms complied with Department of Health guidance, was up to date and we spoke with were familiar with it. Staff were observed obtaining verbal consent from patients before giving care or treatment, this was also confirmed by patients whose care was not observed. Consent forms were fully completed, signed and dated by the consultant, or specialist nurse and the patient, in all eleven sets of notes we reviewed. Patients undergoing chemotherapy, had forms in their notes that identified the planned treatment, the benefits, associated risks and intent of treatment.

One of the eleven sets of notes we reviewed did contain a do not attempt cardio-pulmonary resuscitation (DNACPR) form. It was completed adequately, the patient did have capacity and MCA was not required.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Most staff interacted with patients and those close to them in a respectful and considerate manner. Most patients and their relatives were positive about their experiences of care and kindness offered to them.

Staff demonstrated an understanding of the patients’ emotional needs during interactions. Interactions between nursing staff and patients were professional, kind and friendly.

Staff made sure that patients’ privacy and dignity was always respected, during physical or intimate care. However, we did witness a patient being given bad news on the ward without curtains closed or an offer of an alternative room, which would have provided privacy.

During the October 2015 inspection, we observed there was difficulty in closing curtains due to the limited bed space between beds. However, this had been resolved due to the change in the configuration of the ward space. We saw on the current inspection, curtains could be closed around all beds.

The services regularly received compliment cards and letters of thanks from patients, their friends and relatives. One recently received card said, “Care has been second to none”. Another said the staff were caring and thanked them for their support.

**Friends and Family test performance**
The Friends and Family Test (FFT) response rate for medicine at the trust was 47%, which was better than the England average of 25% from December 2016 to November 2017. However, the
response rate for Mount Vernon Cancer Centre (MVCC) was the lowest for all services managed by East and North Hertfordshire NHS trust at 20%. The annual FFT performance for MVCC between 1 December 2016 and 30 November 2017 was 98%.

Friends and family Test – Response rate between 01/12/2016 to 30/11/2017 by site.

Below is the performance of each ward or unit in the friend and family test:

**Mount Vernon Cancer Centre**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</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>Ann. Perf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 10</td>
<td>171</td>
<td>14%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 11</td>
<td>340</td>
<td>25%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>98%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Patients were generally positive about the support they received from staff on the ward. Patients and relatives told us that the clinical staff were approachable and that they could talk to staff about their fears and anxieties. There were quiet rooms on the ward for patients and relatives to use.
Relatives of some of the patients on the ward said they had also sought support from the staff based in the Lynda Jackson Macmillan Centre. The centre provided information about treatment and side effects, support groups and a range of complementary therapies and other therapies, for example, relaxation classes for all. The centre could also provide counselling, as well as advice on financial assistance. The centre was supported by professional staff groups and volunteers who had been specifically trained.

Counselling services were available upon referral.

The trust operated a chaplaincy service in accordance with NHS Chaplaincy Guidelines 2015 ‘Promoting Excellence in Pastoral, Spiritual and Religious Care’. A lead chaplain led a team of multi-faith volunteers. Staff were knew how to contact spiritual advisors to meet the needs of patients and relatives.

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

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff mostly communicated with patients so that they understood their care, treatment and condition. We saw staff explaining a treatment process to a patient and their relative. However, some patients reported that they had to ask the radiographer to explain the treatment process in more detail as they had been unclear following the doctor’s explanation.

Some patients said they would appreciate a more plain speaking approach throughout their treatment. For example, use the word cancer rather than words like lump, growth or mass.

Patients and relatives felt they could ask questions of the staff.

We observed nurses, doctors and therapists introducing themselves to patients and relatives and involving patients in decisions about their care.

**Is the service responsive?**

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

**The trust planned and provided services in a way that met the needs of local people.**

There were clear admission criteria for the ward. The hospital’s catchment area was large, two million people across Hertfordshire, Bedfordshire, Northwest London and parts of the Thames Valley. Many of the patients did not live locally. Patients were on the ward following urgent referral, to treat symptoms caused by their treatment. For example, difficulty in swallowing and nausea or because they were undergoing daily radiotherapy or chemotherapy and travelling would have been too arduous for them and they were not well enough to reside in the on-site hostel.

Two social work assistants and a social worker funded by Macmillan were based at the MVCC site. They supported people affected by cancer to exercise choice and control at all stages of their care pathway. They liaised with social care teams in the patient local area to support the patient during the discharge process. They also provided emotional and psychological support for
patients, their family members and carers. They were available Monday to Friday 8.30am to 4.30pm.

Meeting people’s individual needs

The service did not always take account of patients’ individual needs. For example, we were not assured translation services were routinely booked and the ward was not set out in a particularly dementia-friendly way. MVCC had an accessibility coordinator who could facilitate access to information in a way patients would understand. Information was available in large print, easy read and audio formats. They could arrange access to British sign language interpreters, lip readers and advocates when necessary.

There were arrangements in place for people who need translation services and staff knew how to access it. However, we saw an ‘emergency translatory staff member’ being used to translate for a patient during a booked appointment. Emergency translation staff were usually the hospital’s staff who spoke the language required, that could be used in an emergency.

There were information leaflets available to patients, their families and carers on the ward, including advice on managing symptoms and on financial matters.

There were suitable arrangements in place for people with a learning disability. The ward had links with the specialist learning disability (LD) team at The Lister Hospital, who provided support when needed. There was a LD link staff member on the ward. They had attended additional training sessions to maintain competency for their role and they shared relevant knowledge, processes and skills to their team.

There was some support for patients living with dementia; the trust employed an admiral nurse. Admiral nurses are trained, developed and supported by Dementia UK, helping patients to live more positively with dementia. Dementia UK is a dementia support and research charity, for anyone affected by any form of dementia in England, Wales and Northern Ireland. The Admiral nurse’s role was to improve the hospital experience for families affected by dementia at individual (holistic care), ward and trust level. They also aimed to improve the experience of family carers in the discharge planning process and build effective working relationships with other Admiral nurse services in Hertfordshire, to support families through transitions in care settings. There were also two dementia link nurses based on the ward. They acted as role models for providing care for patients with dementia. They had attended additional training sessions to maintain competency for their role and they shared relevant knowledge, processes and skills to their teams. However, nursing staff told us they were not confident in their abilities to carry out a MCA assessment, stating it was the medical team who completed these. The ward was not set out in a particularly dementia-friendly way. Dementia-friendly wards are developments to improve care for patients with dementia in acute hospitals. For example, we did not see any evidence of environmental adaptations to orientate, reduce unnecessary cognitive stimulation or reinforce personal identity.

Visiting hours were limited but visiting was permitted at any time for patients approaching the end of their life.

Equipment for example, walking frames, bariatric equipment, adjustable height beds and hoists was available to meet the needs of the patients.
Welcome information was available on the wards for patients and their relatives, which informed them about visiting times, meal times and access to the hospital.

There was good communication between the hospital and their GPs; patients were copied into the letters to their GPs regarding their treatment.

At the previous inspection, we reported the hospital was housed in an old building. Several of the departments at Mount Vernon Cancer Centre were in separate buildings. This meant that if patients were attending other departments, they had to go outside to access them, often in unsuitable attire. During this inspection, we saw staff had access to single use insulated waterproof ponchos and trolley covers for patients. We did not see any patients using these during inspection as the weather conditions did not require such garments.

**Access and flow**

**Patients could access the service when they needed it. Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice.**

Patients could access care and treatment at a time to suit them. Patients had timely access to the wards should they need admission. Beds were always available if required. However, non-emergency patients could wait for long periods of time to see a consultant to discuss outcomes of investigations and plans for treatment. During inspection, we noted one patient had waited five and a half hours on the ward for their appointment.

Treatment for patients with the most urgent needs was prioritised. An electronic referral and booking system was in place, which linked local hospitals directly to Mount Vernon Cancer Centre (MVCC).

There were dedicated administrative staff for scheduling and booking beds. This ensured focus on getting patients to treatment quickly. They booked all parts of the pathway (including patients having radiotherapy and chemotherapy at the same time). Staff were based with the MDT coordinators and the secretaries so there was a good exchange of information.

The wards had access to a range of allied health professionals. We observed physiotherapists and dieticians visiting patients on the ward and saw written entries from the multidisciplinary team such as specialist palliative care nurse and occupational therapist were seen in patients’ records reviewed. Therapy services provided by physiotherapists and occupational therapists were available Monday to Friday. Speech and language therapy (SLT) services were available on request.

Pharmacy services were provided Monday to Friday and included pharmacy assistant support. The pharmacy assistant we spoke with told us that medicines were available on discharge and in a format suitable for the patient. During the 2015 inspection, we observed one patient being told they would have to wait between two and three hours for their take home medicines on day of discharge, because of the volume of work in the pharmacy. During this inspection, we did not receive any concerns about delays for medicine for discharge.

Discharge arrangements were discussed at the daily staff handover. Allocated social workers for the ward supported discharges. Good practice is to begin discharge planning on a patient’s
admission to ensure arrangements could be made in a timely way; however, discharges were mostly planned one day ahead on the ward.

Call bells were mostly answered in a timely way. The majority of patients we spoke with told us that they did not have to wait long before call bells were answered by nursing staff. Some patients did say there were sometimes delays of up to ten minutes at night time. However, this was usually because staff were dealing with other patients.

Complex discharges were supported; social workers based at MVCC liaised with social care teams in the patients’ local areas to support the patient during the discharge process.

**Average length of stay**

From October 2016 to September 2017, the average length of stay for medical elective patients at Mount Vernon Cancer Centre was 2.1 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 5.6 days, which is lower than England average of 6.6 days.

**Average length of stay for elective specialties:**
- Average length of stay for elective patients in Clinical Oncology (Previously Radiotherapy) is lower than the England average.
- Average length of stay for elective patients in Medical Oncology is lower than the England average.
- Average length of stay for elective patients in Clinical Haematology is lower than the England average.

**Average length of stay for non-elective specialties:**
- Average length of stay for non-elective patients in Clinical Oncology (Previously Radiotherapy) is higher than the England average.
- Average length of stay for non-elective patients in Medical Oncology is lower than the England average.
- Average length of stay for non-elective patients in Clinical Haematology is lower than the England average.

**Elective Average Length of Stay - Mount Vernon Cancer Centre**

![Graph showing average length of stay for different specialties at Mount Vernon Cancer Centre compared to England average.](graph.png)

*Note: Top three specialties for specific trust based on count of activity.*
Non-Elective Average Length of Stay - Mount Vernon Cancer Centre

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2016 to August 2017, the trust’s performance was similar to the national average. From September 2017 to November 2017 the trust’s performance was 0%. This may indicate data collection issues from September to November 2017.

(Source: NHS England)

The trust started to use a new patients recording system from September 2017, this resulted in number of significant data quality issues and therefore the reporting of referral to treatment times had been suspended. The trust was working towards returning to national reporting in November 2018 reporting October’s performance.

The trust was reporting locally, March 2018 board minutes information showed the trust did not achieve against the 62-day national standard for Cancer
Cancer performance was reported retrospectively, February’s finalised position is shown below.

Performance February 2018

<table>
<thead>
<tr>
<th>Target</th>
<th>Goal</th>
<th>Threshold</th>
<th>Month</th>
<th>Quarter 4</th>
<th>Year 17/18</th>
<th>Nat Average (Feb)</th>
<th>Nat Average Qtr (Q3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Referral to 1st Outpatient Appointment</td>
<td>&lt; 14 Days</td>
<td>93.0%</td>
<td></td>
<td>97.6% ▲</td>
<td>97.5% ▲</td>
<td>97.7% ▲</td>
<td>95.2%</td>
</tr>
<tr>
<td>Referrals with Breast Symptoms (wef January 2010)</td>
<td>&lt; 14 Days</td>
<td>93.0%</td>
<td></td>
<td>100.0% ▲</td>
<td>97.6% ▲</td>
<td>94.0% ▼</td>
<td>94.1%</td>
</tr>
<tr>
<td>Decision to Treat to 1st Definitive Treatment for all Cancers</td>
<td>&lt; 31 Days</td>
<td>96.0%</td>
<td></td>
<td>92.4% ▼</td>
<td>94.0% ▼</td>
<td>92.7% ▲</td>
<td>97.6%</td>
</tr>
<tr>
<td>Referral to Treatment from Consultant Upgrade</td>
<td>&lt; 62 Days</td>
<td>90.0%</td>
<td></td>
<td>81.0% ▲</td>
<td>78.4% ▲</td>
<td>72.6% ▼</td>
<td>87.0%</td>
</tr>
<tr>
<td>Referral to Treatment from Screening (62 Day)</td>
<td>&lt; 62 Days</td>
<td>90.0%</td>
<td></td>
<td>100.0% ▲</td>
<td>68.0% ▼</td>
<td>68.8% ▼</td>
<td>88.0%</td>
</tr>
<tr>
<td>Second or Subsequent Treatment (Anti Cancer Drug Treatments)</td>
<td>&lt; 31 Days</td>
<td>98.0%</td>
<td></td>
<td>97.0% ▲</td>
<td>93.9% ▼</td>
<td>95.7% ▲</td>
<td>99.6%</td>
</tr>
<tr>
<td>Second or subsequent treatment (Radiotherapy Treatments)</td>
<td>&lt; 31 Days</td>
<td>94.0%</td>
<td></td>
<td>93.6% ▲</td>
<td>90.6% ▼</td>
<td>89.7% ▼</td>
<td>▼</td>
</tr>
<tr>
<td>Second or subsequent treatment (Surgery)</td>
<td>&lt; 31 Days</td>
<td>94.0%</td>
<td></td>
<td>92.3% ▲</td>
<td>87.2% ▲</td>
<td>86.1% ▲</td>
<td>95.4%</td>
</tr>
<tr>
<td>Urgent Referral to Treatment of All Cancers</td>
<td>&lt; 62 Days</td>
<td>85.0%</td>
<td></td>
<td>80.3% ▲</td>
<td>75.3% ▼</td>
<td>73.1% ▲</td>
<td>80.8%</td>
</tr>
<tr>
<td>Urgent Referral to Treatment of All Cancers (following breach reallocation)</td>
<td>&lt; 62 Days</td>
<td>85.0%</td>
<td></td>
<td>- ▼</td>
<td>- ▼</td>
<td>- ▲</td>
<td>-</td>
</tr>
</tbody>
</table>

The Trust did not achieve against the 62 day national standard but did achieve against the
recovery

trajectory and missed the national standard by 0.6% after breach sharing. Senior management oversight continued regarding performance with additional enhancements having been implemented ensuring senior divisional ownership. Commencing in April 2018, each tumour site would complete an assurance overview summary for discussion at the main trust level access board detailing issues, actions and mitigations.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Complaints were not consistently responded to in a timely manner.

Patients knew how to make a complaint or raise a concern, and were encouraged to do so. Information about the complaint process was clearly displayed on the ward and in the main entrance to the hospital. Staff we spoke with were able to describe the complaints process and explain how they would advise patients to raise a complaint.

Ward staff told us they received very few complaints. They used local resolution in the first instance, and formal complaints were processed via Patient Advice and Liaison Service (PALS) who gave formal feedback on actions taken.

Summary of complaints

Mount Vernon Cancer Centre: From November 2016 to November 2017, there were 11 complaints, which took an average of 37.4 days to complete and close. These were most commonly in relation to treatment received. The trust did not sort these complaints into subject areas. This is not in line with their complaints policy, which states complaints should be closed in 30 days of receipt of the complaint.

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

Learning from complaints was shared. Learning for the ward would be shared in team meetings, handover or shared with staff via email. However, as team meetings were not always minuted, there was a risk that any team members not present may miss this information.

Is the service well led?

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. However, the leadership team was relatively new in post and had not had the opportunity to make a full impact, but could articulate the plans for the future.
There was a matron for cancer services at Mount Vernon Cancer Centre (MVCC). A ward manager, consultants and a senior management team, which included a divisional chair, a divisional director and a head of nursing for MVCC, supported them.

Staff at all levels told us the head of nursing at Mount Vernon Cancer Centre (MVCC) provided strong leadership that focused on the needs of patients in the hospital. The ward manager and head of nursing had a visible presence on the ward each day. The head of nursing saw their role was leading by example and being a role model. They were focused on quality improvement, relationship building and teamwork. At the time of the inspection, there was a vacancy for a matron. While recruitment had been undertaken to fill this position, the head of nursing was covering the responsibilities for both the matron and their head of nursing role.

The ward manager would often work in the staffing establishments in times of staff shortages. Staff said they felt supported by their line managers and colleagues.

At the last inspection in 2015, we identified there was a strong leadership team in the Mount Vernon Cancer Centre yet some longstanding risks had not been recognised. During this inspection, we found the leadership team, despite being relatively new in post, could articulate the clinical strategy and their plans for the future. The leaders could see where shortfalls were and how they could be improved. This mostly centred around the infrastructure and providing a modern service within an ageing building, much of which was not fit for purpose.

**Vision and Strategy**

*Although there was now a vision and strategy in place it was very new, staff we spoke with during the inspection were not aware that there was a defined cancer strategy in place. In addition it was too early to see any impact of the strategy.*

There was a clear vision and a set of values, with quality and safety the top priority. The final draft of the MVCC clinical strategy 2018/19 to 2021/22 was presented to the board on 7 March 2018. The leadership team could articulate their plans for the future. It was reported in the strategy, the development of the strategy had taken place over recent months, with the full involvement of the staff at MVCC. It reflected a series of discussions that began in 2016 and was built on a ‘Phase 1’ strategic review approved by the East and North Hertfordshire NHS Trust Board in early 2017.

However, as the strategy was so new, staff we spoke with, during the inspection were not aware that there was a defined cancer strategy in place. The trust strategy team had been working with the leadership of MVCC over the last year to support them with the development of a new clinical strategy, which would enable the service to respond to a wide range of key drivers that it was currently facing.

The strategy set out how the service planned to develop and improve services over the next five years; so it could continue to deliver high quality, innovative cancer care.

The strategic aims to address the drivers for change and to strengthen and develop MVCC were to deliver innovative, high quality and efficient services, with partners, transform how cancer care is provided, harness patient views and technology to transform the environment in which we deliver care and recruit and retain high quality staff.
The trust aimed to demonstrate delivery of the strategy by tracking milestones set out in the document and review the way progress had been made with the cancer division and its leadership team, through the strategy delivery group. The service planned to undertake a formal review of the strategy at year three, and report this to the board. The clinical strategy was underpinned by the existing trust enabling strategies including Improving clinical outcomes, patient and carer experience, people, research and development and information and technology as well as by new strategies to be developed during Year one, including quality and estates.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff were confident to raise concerns, they felt valued and supported in their roles. They said managers were approachable. Staff we spoke with said they felt respected and valued.

Staff felt action was taken to address behaviour and performance when necessary regardless of seniority, for example, when behaviour was inconsistent with the vision and values.

There was information displayed on the ward advising staff how to raise a concern. This suggested that the trust had an ‘open culture’ in which staff could raise concerns without fear. All staff that we spoke with advised that they understood the trust’s policy and would feel comfortable using it if necessary. The trust had a freedom to speak up guardian (FSUG) while not all staff were able to name the FSUG, all were aware of the role and how to contact them.

The hospital had a large team of volunteers who supported the hospital in most departments. They supported various receptions providing a meet and greet service, preparing refreshments, working in all departments as assistants, running activities and fundraising. The volunteers were seen as an integral part of the team.

Governance

The service was developing a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

However, whilst there were governance systems in place as local level informal team briefings where feedback was often given to teams were not always minuted so there was a risk team members not present may miss feedback information.

Senior staff felt that MVCC was represented at board level. We saw evidence issues from the service were brought to the board meetings for example analysis of staffing data any safeguarding issues. The final draft of the MVCC clinical strategy 2018/19 to 2021/22 had been presented to the board on 7 March 2018.

There were effective processes and systems of accountability. Staff were clear about their roles and what they were accountable for. Weekly directorate governance meetings were held, which fed into monthly divisional governance meetings, who in turn reported to the trust governance
group. The head of nursing and ward manager demonstrated awareness of governance arrangements. They described the actions taken to monitor patient safety and risk. This included monitoring risk dashboards, incident reporting and undertaking audits.

Minutes reviewed of the formal three monthly ward meetings had a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described. However, the more regular informal team briefings where feedback was often given to teams were not always minuted so there was a risk team members not present may miss feedback information.

During the 2015 inspection, we reported patients who developed complications during their treatment and who required medical or surgical treatment were transferred to one of the neighbouring trusts by emergency ambulance. The wards had a summary of all transfers; however, a trust incident report was not completed. This meant the hospital did not have an oversight or did not monitor the number and reasons for transfer. Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern. Since the last inspection, a formal pathway for transfer of emergency and urgent patients at MVCC had been developed. It included key contacts related to specific specialities. It stated that if the patient had a condition that required urgent treatment, for example, bleeding, an emergency ambulance was called and patient was transferred to an identified neighbouring trust for ongoing acute treatment. The trust had introduced an urgent transfer and step up book, this included a protocol and guidance for staff to follow in the event of a patient requiring transferring out for acute medical care. Staff used this booklet to document the details of the events leading to transfer and where they had been transferred to. The MVCC doctor in charge of the patients care followed up the patient via telephone daily. This ensured updates were recorded and monitored and the hospital had an oversight and a process for monitor the number and reasons for transfer. Therefore, the trust was now sighted on this risk. We noted not all transfers were recorded as incidents, however, the head of nursing at MVCC carried out a monthly audit of the patients transferred out and used this process to look for trends themes and any learning points.

Management of risk, issues and performance

Although the service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected this was not always effective. Some risks were identified during the inspection that the staff had not recognised.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The cancer division had their own risk register. The risk register was reviewed regularly and contained description of the risk, ratings and controls in place, gaps in control, assurances and action plan. Managers and senior staff were aware of the risks in their individual service areas. All risks mentioned by managerial staff during the inspection were reflected on the divisional risk register. However, we were not assured that other staff were aware and proactively addressed risk areas. Issues we noted during inspection for example a lack of individualised care plans, an unlocked medication trolley, a broken padlock on a medicine refrigerator and items of equipment identified as not suitable for use, had not been noticed or addressed by ward staff.
There were clear lines of accountability including clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line.

The ward manager shared regular reports on incidents with the ward team; reports were displayed in the ward staff room.

Staff we spoke with felt it was easy and open to raise concerns.

**Information Management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service completed local audits as part of service performance measures reported to the trust board. For example, the monthly audit of the patients transferred out was reported to the management team and was used to look for trends, themes and learning points.

Though the governance framework including committee reports and performance reports, the board was able to receive relevant and where required, targeted information on quality and safety for the ward.

**Engagement**

The trust tried to engage with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

One of the divisional aims was to harness patient views by working with patient groups and use the friends and family test (FFT) data to understand the needs of patients and improve the customer service aspect of care. Staff within MVCC recognised the importance of gathering the views of patients and actively sought feedback. We saw FFT questionnaires and patient comment cards available in areas we visited. Staff were aware sometimes only small number of FFT forms returned so were looking in to other means of gaining feedback.

The ward displayed information for patients and their families about ways in which they could comment on their experiences in a confidential setting, such as through accessing the patient advice and liaison service.

Leaders and staff understood the value of staff raising concerns the ward manager and head of nursing had an open door policy. Staff said they felt able to share concerns and feedback with managers as they were often on the ward and the ward manager was often working alongside them.

The hospital was a member of the East of England Local Cancer Network. The East of England Clinical Network for Cancer has a vision to improve quality of life and outcomes for patients by driving out unacceptable variation in pathways of care; reducing inequality of access to all aspects of care, and redesigning the way we work with primary care.
Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they did not go quite so well, promoting training, research and innovation.

Managers we spoke with told us they were developing a culture for continuous learning, improvement and innovation. We saw evidence where changes had been made. The head of nursing was particularly proud of the work developing the urgent transfer and step up book, this protocol and guidance for staff ensured patients were recorded and monitored providing the organisation with the necessary oversight.

The hospital had a research and clinical trials department. Nationally MVCC were in the top 100 trusts for research. Patient attending MVCC had access to clinical trials and participating in research.
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, bereavement support and mortuary services.

The Mount Vernon Cancer Centre is part of East and North Hertfordshire NHS Trust. It is situated in Hillingdon, Middlesex on the site of the Mount Vernon Hospital, owned by Hillingdon NHS Trust. It is approximately 33 miles from East and North Hertfordshire NHS Trust’s main hospital, the Lister in Stevenage.

The trust had 1,664 deaths from October 2016 to September 2017. Data was not provided for the Mount Vernon hospital site alone.

(Source: Hospital Episode Statistics)

Mount Vernon Cancer Centre (MVCC) includes a hospice on site which provides end of life care. The trust provides multi faith facilities, a mortuary and bereavement office. However, the Mount Vernon Hospital mortuary owned by the Hillingdon NHS trust is currently used by MVCC as there is no mortuary for East and North Hertfordshire Trust within the footprint of the MVCC.

Palliative and end of life care is provided in the main through:

- **Michael Sobell House Hospice:**
  - 16 bed in-patient unit
  - day centre
  - patient and family support (including bereavement counselling)
  - rehabilitation support

- **Mount Vernon Cancer Centre Specialist Palliative Care Team:**
  - multi-professional advisory service comprised of palliative medicine consultant and clinical nurse specialists
  - face to face assessment available 9am to 5pm Monday to Friday
  - telephone advice from hospice overnight

(Source: Routine Provider Information Request (RPIR) – Context Acute)

However, some patients who are at the end of their life are also cared for within the inpatient wards at the MVCC. These are wards 10 and 11.

The term palliative care describes care given to relieve symptoms rather than treat the cause of an illness, the aim of which is to improve the quality of patient’s life when they have a life-limiting
condition. Palliative care can help at all stages of such an illness, from its diagnosis, during on-
going treatment and at the end of someone’s life.

From March 2017 to February 2018 there were 995 referrals to Michael Sobell House of which 947 had a cancer diagnosis.

The in-patient unit at Michael Sobell House comprised 16 beds arranged as four bedded bays and individual side rooms. There were additional side rooms within the footprint of the unit but these were not utilised as the unit was funded to provide 16 in-patient beds.

The trust reported 567 referrals to the inpatient unit at Michael Sobell House from January 2017 to December 2017. Of these 296 patients were admitted. 45% of admissions were from Hertfordshire, 41% came from Hillingdon and 8% from Harrow, with the remaining patients coming from a wider geographical area.

Data provided by the trust indicated there was an average length of stay in the in-patient unit at Michael Sobell House of 11 days.

The day centre team provided advice on symptom control, as well as counselling, complementary therapies, creative arts as therapy, crafts and outdoor activities. There were 12 places, three days per week. On Mondays, places were reserved for carers to attend. Staff offered carers counselling and provided them with advice and information. Carers could meet and spend time with other carers and in addition could have complementary therapies. On Tuesdays, staff administered a number of clinical procedures such as infusions. Wednesday was specifically for women to attend and Thursday was a day specifically for men. Places on Friday were for both men and women but tended to be for the older adults. The day centre team worked collaboratively with community services (GPs, Macmillan nurses and district nurses) to enhance the advice and support each patient received from their community team.

Data provided by the trust indicated 112 patients were referred to and attended the day centre from January 2017 to December 2017. Of these, 69% were from the boroughs of Hillingdon or Harrow and 22% from Hertfordshire, with the remaining patients coming from a wider geographical area.

We carried out an inspection from 20 to 22 March 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Prior to the inspection we reviewed information we had about the service and information from stakeholders.

We visited the in-patient ward and day centre at Michael Sobell House (MSH) and wards 10 and 11 in the MVCC.

During the inspection visit the inspection team:

- Spoke with six patients and a relative of a patient
- Spoke with 30 members of staff including senior managers, doctors, clinical support workers, nurses, housekeepers, complementary therapists and receptionists.
- Reviewed eight patient records relating to assessments and care plans, 11 medicines administration charts, and five DNACPR orders.
Following the inspection we reviewed additional performance data and other information provided by the trust.

The service was last inspected in October 2015, when we rated it as requires improvement overall. At that inspection we rated safe as inadequate, responsive and well led as requires improvement and effective and caring as good.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

There was no mandatory training for staff in relation to end of life care although some local training was provided.

**Overall mandatory training rates**

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

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

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and nursing staff in end of life care at Mount Vernon Cancer Centre is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>27</td>
<td>32</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (includes management of inoculation injuries &amp; hand hygiene)</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>27</td>
<td>32</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>29</td>
<td>32</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>30</td>
<td>32</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The overall completion rate for nursing staff was 100.0%. Of the eight mandatory training courses delivered by the trust, six met the completion rate target of 90%.

Staff valued the fact that mandatory training was provided in the classroom rather than being computer based.

The trust reported that 80% of staff in MSH in-patient ward had completed basic life support training.

Training in dementia awareness, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was not included on mandatory training.

End of life care training was not part of the mandatory training delivered face to face. Nursing staff told us staff were given a booklet to read about end of life care and were required to sign to say they had read the booklet.

The senior nursing team for MSH said they had made representations to the clinical nurse lead for end of life care for end of life care training to be reinstated as a classroom session, but had been unsuccessful.

The removal of end of life care training from mandatory training was identified on the end of life care risk register. A review of this on 28 March 2018 identified that the booklet was not being given out during mandatory training sessions; therefore there was no provision of information to staff on end of life care.

A lecturer practitioner had provided training for staff in the MVCC and MSH on different aspects of End of Life Care. They provided a training day on the Five Priorities for Care of the Dying Person (Leadership Alliance, 2014.) Out of a total of 32 staff working within end of life care, 17 staff had attended. Nine staff from MSH had attended this training.
Of the seven mandatory training courses delivered by the trust six met the completion rate target of 90%.

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

There was a large volunteer workforce, comprised of more than 300 people at the MVCC, who were coordinated through the volunteer coordinators under the community engagement manager. All volunteers underwent a robust recruitment process including checking of references and disclosure and barring system checks. They undertook induction, mandatory training and communication skills training and were managed on a day to day basis within the trust teams.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust reported one safeguarding concern relating to patients receiving end of life care from February 2017 to February 2018. This was related to a concern about care that had been provided externally to the trust.

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. A social worker employed by the trust, was based at the MVCC and acted as the lead for adult safeguarding on site. They linked with the trust safeguarding lead and the safeguarding team at the Lister Hospital. They also provided training for staff on site.

The social worker attended the morning shift handover at MSH and safeguarding concerns were discussed with the multi-disciplinary team.
Nursing staff were aware of the signs of abuse and they told us they would report any concerns to the person in charge of the shift or a consultant. They were aware of the role of the social worker and said the social worker followed through on concerns and ensured they were addressed. A member of staff said they would not discharge a patient if there were concerns which might affect the person at home, until actions to protect the person had been agreed.

A member of staff gave us an example of a safeguarding concern. They passed on the concern to the safeguarding team with the patient’s permission and they said it was dealt with extremely well. They told us the patient received help and thanked them afterwards.

**Safeguarding training completion rates**
The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical and nursing staff in end of life care at Mount Vernon Cancer Centre is shown below:

**Nursing staff**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff was 93%. Of the four safeguarding training courses delivered by the trust all met the completion rate target of 90%.

**Medical staff**

<table>
<thead>
<tr>
<th>Training module</th>
<th>Trained staff (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate (YTD)</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The overall completion rate for medical staff was 100.0%. Of the four safeguarding training courses delivered by the trust all met the completion rate target of 90%.

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

**Cleanliness, infection control and hygiene**

Infection prevention and control was not managed well. Staff adhered to hand hygiene procedures but did not always monitor and adhere to high impact interventions to reduce the risk of infection. Issues related to the environment in the in-patient ward at MSH increased the risk of infection.

The ward manager of the in-patient ward at MSH displayed the ward’s performance in relation to MRSA and *Clostridium difficile* on a notice board in the ward corridor. There were no reported cases of healthcare associated MRSA since April 2017 and one case of *Clostridium difficile* since April 2017.

National guidelines and quality standards (National Institute of Health and Care Excellence, NICE QS61) identify procedures which, if completed, minimise the risk of infection associated with intravenous devices (cannulae inserted into blood vessels) and urinary catheters.

The trust had a series of audits to be completed monthly, to assess staff compliance with these procedures in line with national guidance. Staff on the in-patient ward at MSH did not complete these audits regularly and some data was missing. When data was omitted, it was not always clear whether there were patients on the ward at the time requiring these checks or if the checks had not been completed. Data was supplied for five of the six months from August 2017 to December 2017 and for March 2018. Of these, results for daily checks of intravenous devices to identify early signs of inflammation or infection were only recorded on two occasions, when there was full compliance on one occasion and a score of zero on the other occasion. Intravenous device insertion and care results were omitted in all the months for which data was provided. Urinary catheter insertion and care audit results were provided in each of the five months and did not meet the target of 95% in one month when the score was 80%. This meant we were not assured that staff were adhering to national guidance in relation to these procedures.

Hand sanitising gel was available at the entrance to all clinical areas and was situated by each bed in the in-patient ward. In the day centre, hand sanitising gel and handwashing facilities were available in each of the consulting and treatment rooms.

Lever-operated taps were in place at all hand wash basins, with liquid soap dispensers and paper hand-towel dispensers nearby. This was in line with health building notes HBN 00-09. Personal protective clothing and equipment (PPE) was readily available within all the areas.

We observed ward and departmental staff adhering to good infection prevention and control procedures, including arms ‘bare below the elbows’. We saw appropriate compliance with washing and sanitising hands.
The trust monitored compliance with hand hygiene procedures through monthly hand hygiene audits. However, audits were only submitted by the in-patient ward on six occasions from March 2017 to February 2018. Compliance was 100% on each occasion.

Staff were caring for a patient with MRSA in a side room of the in-patient ward during our inspection. There was a sign on the door to remind staff and visitors that precautions were required to prevent the spread of infection to others. We observed all staff adhered to these precautions. We spoke with the patient and they told us all staff always wore PPE and washed their hands when they entered and left the room. Soiled dressings and linen were placed in the appropriate coloured bags to ensure they were handled or disposed of correctly.

We inspected facilities provided for end of life care in MSH and found issues with maintenance of the fabric of the building made the environment difficult to clean. The floors of the inpatient ward were marked and appeared soiled in places. The poor condition of the flooring made it difficult to keep it looking clean. Surrounds to the hand wash basins in side rooms were damaged and the surface was missing in places exposing bare chipboard. This made them difficult to clean and the uneven surface increased the risk that micro-organisms could accumulate. Therefore the risk of infection was increased.

The ward manager told us the trust estates department were aware of the condition of the floors and were reporting it to the trust management team.

The kitchen was visibly clean and tidy and the required checks of the temperature of the refrigerator and the temperature of hot food were recorded daily.

The environment within the day centre was visibly clean.

Staff used green ‘I am clean’ stickers to label equipment when it had been cleaned. Equipment labelled as clean was visibly clean on inspection.

Nursing staff and managers had identified issues with cleanliness of the environment prior to the inspection. They raised this with the sub-contractors providing the housekeeping service and placed it on the risk register. The management team told us they had secured additional hours of cleaning for MSH within the previous month to improve standards of cleanliness and this was recorded on the MSH risk register.

A Patient Led Assessment of the Care Environment (PLACE) audit was completed during 2017. The in-patient ward at MSH scored 100% for cleanliness. Trust audits of cleaning standards showed an overall score of 98% from 1 April 2017 to 20 March 2018.

Ward staff were aware of the procedures to be taken when performing ‘last offices’ in order to minimise infection risks. The term last offices relates to the care given to a body after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health, safety and legal requirements.

The trust provided guidance to reduce the risk of spreading an infection when providing care for people after death including the wearing of gloves, aprons and the use of body bags.
Environment and equipment

The premises used by the service were not well maintained. Although some improvements to the environment in MSH had occurred since the inspection in 2015, we found significant concerns remained. Walls were damaged in the ward bay areas and side rooms, window restrictors were not in place and accessibility to the toilets was poor, increasing the risks to patients with a disability.

At the inspection in October 2015 we identified concerns with the environment on the in-patient ward at MSH. At this inspection some of the major issues such as the roof and ceilings had been addressed but some concerns remained. Issues with expired single use items identified in October 2015 had been addressed and all items we examined were within their use by dates.

The walls were poorly maintained on the inpatient ward and one single room could not be used due to the shower not functioning. In addition to the damage to the surface of the walls in the bays and side rooms reported under the cleanliness, infection control section of this report, there were numerous plaques and frames attached to the walls to hold equipment which was no longer used. We observed a wooden plaque had two screws which protruded by at least a centimetre, increasing the risk of injury to a person.

Window restrictors were not always in place. An effort had been made to limit opening of windows by using door chains. However, some of these were not fastened and some were able to be unlatched easily.

On the third day of the inspection a radiator had started to leak in an in-patient bay area and there was a considerable amount of water on the floor. The housekeeper had noticed it and attended to it promptly, and said they were about to report it to the maintenance department. We were told this was not an infrequent occurrence. Disabled access to toilets on the inpatient ward was difficult and there were no grab rails or bars to improve safety and accessibility.

The hair salon in the day centre could not be used as the wash basin was cracked and the surround required replacement. The timescale for dealing with this was unclear.

Staff from the estates department had completed a log of all the areas which required attention but there was no timescale or action plan to address the issues that the ward staff or ward manager were aware of.

The risk register for cancer services showed a number of risks were identified with the environment within the MVCC with a score of 20. Whilst the MSH was not specifically mentioned it was clear there were ongoing discussions regarding the service level agreement and the future of this site. Risk assessment were in place.

The PLACE audit completed in 2017 gave a score of 100% for the condition, appearance and maintenance of the environment on the in-patient ward at MSH. Given the observations we made during this inspection and the previous inspection in October 2015 in relation to the condition of the environment on the ward, we were unable to understand how this score was achieved.

Equipment was tested for electrical safety and all that we reviewed was within the dates for safe use.

The trust used nationally recommended syringe pumps to deliver continuous infusions of medication to improve patients’ symptom control at the end of their life. Syringe pumps were available within MSH. We checked 14 on the in-patient ward and one in the day centre. These had
all been safety checked and had been serviced within the past 12 months and a supply of new batteries was available. Keys were available to lock the safety covers on the syringe pumps.

The resuscitation trolley had a tamper proof tag to ensure the contents had not been accessed between checks. Resuscitation equipment was checked daily and the checks documented.

MSH did not have a mortuary. A cooling room, which allowed the deceased patient to remain at the hospice so that relatives were able to spend time with their loved one before going to the mortuary at MVCC or a local funeral director had previously been used. We identified concerns with the state of repair and maintenance of the room at our inspection in October 2015. Currently, we were told the room had recently been taken out of use as the air conditioning system was not working and it was not possible to repair it. The trust had an informal agreement to allow deceased patients to go to the mortuary at the Hillingdon NHS trust. A cooling mattress was used when a deceased patient was not moved immediately to the mortuary or undertakers.

Assessing and responding to patient risk

Patient’s individual risks were assessed and monitored and staff provided support to maintain their safety. A formal treatment escalation plan was being developed to ensure best practice when a patient’s condition deteriorated.

Medical staff assessed patients on admission to the ward and reviewed their condition daily. Their resuscitation status was reviewed and ceilings of care were agreed with the patient and their relatives to identify the most appropriate steps to be taken by staff if their condition deteriorated. A consultant said they had a discussion with each patient about what they wanted and the plan for escalation and we saw documentation confirming this in four of the care records we reviewed.

When vital signs observations were completed for patients, staff used the National Early Warning Score (NEWS) to identify if a patient’s condition was starting to deteriorate and prompt staff to seek medical review when required.

We saw two examples in a care record, where staff responded to a rise in the NEWS score by escalating the patient’s condition to medical staff. The person was reviewed promptly in both cases.

The trust had a procedure in place to provide guidance for staff to ensure the prompt transfer of a patient if they became unwell and required additional interventions. However, there was no formal treatment escalation plan in place. The service was undertaking a quality improvement programme to review observations and the escalation of patients when their condition deteriorated. Managers told us and minutes of the end of life strategy group confirmed, that a treatment escalation plan was in the process of being developed.

Nursing staff completed individual risk assessments to identify patient’s risks of developing pressure ulcers and nutritional risk. Care plans demonstrated these risks were taken into account within the care plans. For example, when a person was at high risk of developing pressure ulcers pressure relieving equipment was in place and the person was assisted to move their position regularly.

Oral assessments were completed to assess when additional mouth care was required for a patient’s comfort and well-being.
An individualised end of life care plan was used within the last few days and hours of life. It provided a structured approach to prompt staff to conduct regular checks on patients to assess and manage their fundamental care needs. Care needs such as changes required to medication, an assessment of psychological needs, or the need to complete mouth care was monitored by staff during these checks. Patient records demonstrated ward staff were completing an hourly check of comfort measures for patients who had an individualised end of life care plan in place. In the last few days of life when a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place, vital signs observations were discontinued.

Nurse staffing

The service did not have robust evidence to demonstrate that staffing levels were set appropriately to meet the changing needs of their patients throughout the 24 hour period. Staffing levels at night increased risks to people using the service and had not been addressed over a significant period of time.

Steps had been taken to manage the current nursing workforce as effectively as possible, but there were concerns about staffing levels at night and during sickness absence. Managers, recognised this, but at the time of the inspection, a robust solution had not been identified. In addition, changes to the level of funding from charitable sources threatened the sustainability of the service.

Nurse staffing for end of life care at MVCC was comprised of staff working on the in-patient ward, day centre, palliative care clinical nurse specialists and a range of specialist nurse support posts such as the community liaison manager and lecturer practitioner.

Overall staffing rates

Data initially provided by the trust was not broken down by ward and the number of staff working in end of life care at MSH was not identifiable. Following the inspection, the trust reported their staffing levels in March 2018 in whole time equivalents (WTE) as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Inpatient unit (MSH)</th>
<th>Day Centre (MSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses</td>
<td>16.24 WTE</td>
<td>2.6 WTE</td>
</tr>
<tr>
<td>Clinical Support Workers</td>
<td>8.86 WTE</td>
<td>0.6 WTE</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>1.0 WTE</td>
<td></td>
</tr>
<tr>
<td>Administrator/ward clerk</td>
<td>1.0 WTE</td>
<td>0.6 WTE</td>
</tr>
</tbody>
</table>

The fill rate was unable to be calculated as we did not have information on the planned staffing levels for nursing staff in end of life care.

Vacancy rates

From December 2016 to October 2017 the trust reported a vacancy rate of 2.4% for nursing staff in end of life care at Mount Vernon Cancer Centre including MSH, which is better than the trust target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates
From December 2016 to October 2017 the trust reported a turnover rate of 4.9%% for nursing staff in end of life care at Mount Vernon Cancer Centre including MSH, which is better than the trust target of 12.7%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From December 2016 to October 2017 the trust reported a sickness rate of 4.1% for nursing staff in end of life care at Mount Vernon Cancer Centre, which is worse than the trust target of 3.3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

A senior manager told us nurse staffing levels for the in-patient ward were initially set using the safer nursing care staffing tool. The tool provides an assessment of the care hours required for a ward, based on the number of care hours each patient required each day over a period of time. However, they expressed some concern as to its sensitivity and relevance to palliative and end of life care. The tool was initially developed, tested and validated in an acute hospital setting.

The senior manager told us the staffing levels for the in-patient ward at MSH had not had a full review of nurse staffing and skill mix for several years and the staffing establishment was historic. Staff within the service said they were not clear how the budget for nurse staffing was set and how the information gathered on a daily basis on staffing and patient dependency was utilised by the trust. The trust provided us with a nurse staffing review report which was presented to the risk and quality committee in December 2017. This indicated that MSH had been included in the review. However, whilst there were clear references to specific issues which were taken into account for some wards/units which may have affected staffing requirements, there was no evidence of these being considered for MSH. The relatively small number of beds in the unit had an impact on the ability to roster staff efficiently and the large proportion of patients requiring breakthrough pain relief and controlled drugs was also a factor.

Information provided by the trust indicated they used a ‘Safecare’ tool to monitor nurse staffing levels on all wards on a daily basis. This assessed the number of care hours provided against the planned levels. The trust’s safer nurse staffing report for November 2017 stated that the number of shifts where staffing initially fell below agreed staffing levels was 2.2% and the RAG rating associated with this showed they were green (safe).

The nursing leadership team for the service had recently completed their own review of nurse staffing as they identified concerns with the number of registered nurses available in the afternoon and evening. They said that as there were only two registered nurses on duty in the late afternoon and evening, it was difficult to provide timely response to patients requiring breakthrough pain relief. This is pain relief given when a patient’s regular prescribed medicines are not always fully effective. They had therefore made the decision to change the shift pattern to enable an additional registered nurse to be available during the afternoon and evening within the current staffing budget. They had obtained agreement from the trust for this.

Nursing staff felt this had resolved most of the staffing concerns. However, they identified that because only two registered nurses were available on night shifts, there were similar problems at
night. The director of nursing had said she considered this unsafe. In addition, when a nurse was on their break during the night, they had to be called back to the clinical area to provide pain relief as controlled drugs required two nurses to check and administer them. There was no cover available from the MVCC.

A patient who was very positive about the care provided, told us they sometimes had to wait 10 to 15 minutes for assistance. However, they said that if they were in pain, staff tried to ensure they received pain relief quickly.

The nursing leadership team also raised issues with obtaining cover for sickness absence as the temporary nurse staffing office (NHSP) was based at the Lister Hospital and the majority of the staff provided by NHSP were local to the Lister Hospital and did not want to travel to MSH.

Managers told us that all the clinical support worker posts (CSW) were funded by a charitable organisation. The charity had informed the trust that the amount of funding to the trust would be substantially reduced from the following month. Therefore, there would be further pressure on staffing budgets and it was unlikely that further funding to address the current issues would be forthcoming.

There were two clinical nurse specialists in post (1.6 whole time equivalents (WTE)). 0.6WTE was allocated to provide input to the wards in MVCC and 1WTE to a project to provide early supportive care to patients and families early in the palliative care process, for patients whose cancer was incurable but who might still be continuing to receive treatment.

**Medical staffing**

The trust has reported their staffing numbers below for year of 2016/17 and year to date which covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
</tr>
<tr>
<td>End of life care</td>
<td>2.2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

The fill rate for medical staff at Mount Vernon Cancer Centre in 2017/18 year to date was the same as for 2016/17.

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

The staffing levels identified above relate to consultant staff. In addition, there were two registrar posts, one WTE (whole time equivalent) GP trainee and a Foundation Year 1 (FY1) doctor. However, at the time of the inspection, one of the registrar posts was vacant due to maternity leave and there was no allocated FY1 doctor.

Consultants told us they were unsuccessful in recruiting to the registrar vacancy, but previous trainees provided some on call cover out of hours. They were hoping the issue would be resolved.
in August 2018 when the posts were rotated. Currently, consultants covered the gaps in the rota which could not be filled.

Junior doctors said they were able to attend training and book annual leave. They said they had good access to consultants for advice and received a good level of support from the consultants.

**Vacancy rates**
From December 2016 to October 2017 the trust reported a vacancy rate of 25.0% for medical staff in end of life care at Mount Vernon Cancer Centre, which is worse than the trust target of 6%. However, numbers of staff in end of life care are low which should be taken into consideration.

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

**Turnover rates**
From December 2016 to October 2017 the trust reported a turnover rate of 18.5% for medical staff in end of life care at Mount Vernon Cancer Centre, which is worse than the trust target of 12.72%. However, numbers of staff in end of life care are low, which should be taken into consideration.

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

**Sickness rates**
From December 2016 to October 2017 the trust reported a sickness rate of 0.0% for medical staff in end of life care at Mount Vernon Cancer Centre, which is better than the trust target of 3.3%. Numbers of staff in end of life care are low which should be taken into consideration.

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

**Bank and locum staff usage**
From December 2016 to October 2017, 42 shifts at the junior doctor level and five shifts at consultant level were covered by bank staff. There was no agency usage in this period.

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

**Records**
Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Nursing care plans were stored in closed cupboards or drawers within the bay area of the ward. Medical records and nursing records which contained more sensitive information were stored in the medical staff office.

We reviewed eight care records. Records were legible, and the entries, dated, timed, signed and the designation of the person making the entry was identified. Medical records contained a comprehensive review of the patient at least daily. There was a good record of discussions with the patient and/or their close relatives and records demonstrated the input of the multi-disciplinary team.
Nursing care records contained nursing assessments and care plans which were fully completed and reflected each patient’s individualised needs. When the end of life care plan was not being used, the trust’s ‘essential nursing bundle’ was completed two hourly, to document nursing interventions to check on the patient and provide support and care.

We reviewed two care records where the individual end of life care plan was used. There was a clear rationale for why the care plan was initiated. The care plan was well structured and completed, showing daily review and assessment of the patient’s symptoms and care needs.

A structured assessment used for patients with cancer was also utilised within the care records to provide a holistic approach to care.

DNACPR orders were kept at the front of the patient record to ensure they were readily available if required. The records we reviewed were completed appropriately and signed by a consultant.

**Medicines**

Medicines were prescribed, given and stored in accordance with best practice. Processes were in place to improve the safety of drugs given continuously via a syringe pump.

At the last inspection in October 2015 we identified some issues with medicines management. At this inspection we found medicines these issues had been addressed and medicines were managed safely.

Medicines were stored safely in a locked room on the in-patient unit. However, a cupboard used to store oral medicines was unlocked on the first day of the inspection. There was a note on the cupboard stating the lock was broken and had been reported to the maintenance department. When we re-visited the ward the following day the issue had been addressed. We checked the temperature of the room used to store medicines and the refrigerator and found they were within acceptable limits.

Controlled drugs were stored and managed safely and in line with legislation. We checked four controlled drugs and the controlled drugs register and found the required records were correctly maintained.

We observed the administration of oral controlled drugs and three syringe pump medication changes. All were completed safely and competently in line with professional and trust guidance.

We found an opened bottle of catheter infusion fluid outside a patient’s side room in the ward corridor. Fluids such as this should be stored securely to reduce the risk of an unauthorised person accessing them and tampering with them. We spoke with the ward manager about the risk this posed and it was removed. When we returned the following day, the fluids were stored securely.

We spoke with two patients about the administration of their medicines. They told us staff always checked their name and date of birth before administering their medicines and stayed with them until they had taken them.

We checked 11 drug administration charts and found medicines were prescribed in line with best practice and records of administration were consistently completed. Staff recorded patient’s allergies and all records were legible, clearly dated and signed. The drug administration chart had
a separate section for drugs given in a syringe pump to improve safety and reduce the risk of errors. These were prescribed in line with guidance.

Staff had access to drug compatibility charts for use with syringe pumps to ensure that drugs were only mixed when it was safe to do so. They also completed a syringe pump checklist to ensure a systematic approach was taken and checks fully completed.

The trust had a medicines policy and a range of guidelines relevant to prescribing and administration of medicines in end of life care. This included guidelines for prescribing anticipatory medicines (medicines prescribed in advance to manage anticipated symptoms) and guidelines for the management of oral medication in adult patients with swallowing difficulties or with enteral feeding tubes.

The multi-disciplinary team assessed patient’s needs for anticipatory medicines and ensured they were prescribed and administered to manage their symptoms. Anticipatory medicines are medicines prescribed for use on an “as required” basis to manage common symptoms that can occur at the end of life.

Staff and patients had access to a pharmacist five days each week. They provided support to junior doctors and ward staff with prescribing and with new admissions, ensuring each patient’s medicines history was recorded and medicines reconciliation was completed. They provided specialist advice to staff in relation to prescribing, particularly when multiple drugs were required and for bisphosphonate prescribing. Bisphosphonates are drugs that in certain situations can help to protect bones against some of the effects of cancer, such as pain and weakness.

We observed the pharmacist explaining the medicines a patient was taking home with them, to the patient and their close relative. They explained slowly and clearly and gave them opportunity to ask questions. The patient was receiving a large number of medicines and they checked that the patient and relative were clear about each one.

However, staff told us patients receiving their medicines via a syringe pump had their syringe pump removed prior to discharge when the discharge was planned. They were given a bolus dose of the medicines prior to discharge and staff arranged for the community nurse to attend them at home and provide a syringe pump. This was to ensure that syringe pumps were available for in-patient use as they had experienced difficulties in retaining them in the past. However, it increased the risk the person’s symptoms may not be adequately controlled in the interim.

Incidents

Incidents were managed well and learning from them was implemented.

At the inspection in October 2015 we found that when incidents occurred, reviews and investigations were not always adequate. Improvements were not always made when things went wrong. At this inspection we found incidents were appropriately investigated and learning was identified and communicated to staff.

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 January 2017 to December 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 one serious incident (SIs) in end of life care which met the reporting criteria set by NHS England from January 2017 to December 2017. This serious incident was classified as an abuse/alleged abuse of adult patient by staff.
(Source: Strategic Executive Information System (STEIS))

This incident was not related to MVCC and occurred on another of the trust’s sites. It was related to an individual staff member and there was no specific learning for staff from the incident. There were no serious incidents in relation to MSH.

We spoke with five medical, nursing and other staff about incident reporting and they told us they were encouraged to report incidents and they were aware of their responsibilities in reporting incidents.

Staff told us they received feedback about incidents and learning from them. They were able to identify changes which had occurred in relation to medicines errors and falls. The in-patient ward held a daily safety huddle led by a senior clinician or nurse, in which safety concerns and learning from incidents were discussed.

The ward manager told us the main incidents over the last six months had been falls and medicines errors. They also reported significant numbers of pressure ulcers, but these were ulcers that had been were present on admission to hospital. They gave us examples of action taken to reduce falls. These included: the introduction of safety huddles and intentional rounding (comfort rounds to ensure patients are checked and their needs attended to promptly), supply of slipper socks, the use of sensor alarms to detect patient movement and the placement of patients within areas to increase visibility. We were told the number of falls had reduced by 54% over the last year. However, data provided by the trust showed the number of falls fluctuated between zero and 8.06 falls per 1000 bed days from March 2017 to February 2018, and did not show evidence of a downward trend.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff were aware of the duty of candour in that it was about being, “Open and honest in everything we do.” They said they would speak with the patient and/or their relative and give a full explanation. They were not aware of the requirement to send a letter of apology to the patient and a written explanation of the investigation and action taken to reduce the risk of a similar incident occurring in the future.
However a doctor told us they had been made aware of the requirement to send a letter in a training session they had attended the previous week.

Staff were aware of the major incident plan. They told us the MVCC had experienced a loss of power and patients had been transferred out of the areas for 24 hours in February 2018. The MSH had accepted patients from the area as they were unaffected.

**Safety thermometer**

The NHS safety thermometer is an improvement tool to measure patient “harms” and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections.

Staff collected safety thermometer data monthly. From April 2017 to March 2018 no new harms were reported by the in-patient ward at MSH.

The results from the safety thermometer were kept in the ward meeting folder and in the staff room. The ward displayed the number of pressure ulcers and falls on a display board on the main ward corridor along with other quality indicators. Although the number of falls fluctuated from month to month as described above, there were no hospital associated pressure ulcers on the inpatient ward from March 2017 to February 2018.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. They assessed staff compliance with guidance and identified areas for improvement.

Policies and guidelines for end of life care were based on national guidance and provided references to these. For example, National Institute of Health and Care Excellence (NICE) quality standards QS13 “End of Life Care for Adults” (November 2011, updated March 2017), “Five Priorities for Care of the Dying Person- one chance to get it right” (Leadership Alliance, June 2014).

Staff completed individualised care plans for patients receiving end of life care. These care plans included a holistic assessment, including assessment of spiritual and psychological needs. This was in line with national guidance such as NICE guideline NG31, ‘Care of dying adults in the last days of life’ (2015) and ‘Five Priorities for Care of the Dying Person’.

The service also used the PEPSI COLA assessment as a tool to assess patient’s needs. This assessment was cited in the national Gold Standards Framework as a means of holistically assessing the supportive and palliative care needs of people with cancer. We saw examples of this which had been fully completed in patient’s care records. PEPSI COLA is an aide memoire to ensure consideration is given to patient’s (P)hysical, (E)motional, (P)ersonal needs, (S)ocial
support, (I)nformation and communication needs, (C)ontrol and autonomy, (O)ut of hours,(L)iving with your illness and (A)fter care.

A range of audits were completed to assess compliance with national guidance as identified below. The service reviewed the outcomes of the audits at the end of life strategy group and actions to improve compliance were identified on the end of life strategy group work plan.

Audits of the use of the end of life care plan assessed the number of patients for whom the end of life care plan was utilised in the last days and hours of life. Data supplied by the trust indicated that from September 2016 to August 2017, of the 132 deaths in the trust, 65 patients had the end of life care plan in place. Data for MSH showed that 13 out of 17 patients who died had an end of life care plan (Source: P87.03 Performance dashboard EOLC.) These results indicated that further improvement was required trust wide, however the results for MSH showed better compliance. Achieving improvement in these results was part of the work plan for the end of life strategy group.

The trust completed an audit of identification of adults in the last days to hours of life and anticipatory prescribing for patients in 2017. (NICE Clinical Guideline 31 - Care of the Dying Adult 2015) The trust provided the results of the audit which showed that further improvement was required in both areas and concluded that use of the end of life care plan would improve communication and prescribing in patients at the end of their life. However the audit did not include patients cared for at the Mount Vernon site Therefore the action identified in the paragraph above would also improve results in relation to this aspect of care.

An audit plan for end of life care services at the trust for the 2017/2018 financial year was available and staff completed a range of audits to review the care of patients at the end of their life at MVCC. These included audits of steroid use against clinical standards and audits of referrals to the MSH.

An audit was undertaken to assess the awareness of junior doctors of guidelines on the management of constipation in end of life care and whether doctors adhered to the guideline. The audit identified that 90% of doctors were aware of the guidelines but assessment and treatment were inconsistent. All the doctors felt they needed more training. As a result, additional training was undertaken with junior doctors in October 2017.

An audit was completed to review the use of the syringe pumps to check they were routinely locked to prevent tampering/accidental changes to pump and to assure it was in line with trust policy. This indicated that whilst the pump boxes were locked the key pads for the pumps were not always locked. Actions to address the issues had been identified including making changes to the training of staff in their use.

The service had introduced daily safety huddles to discuss safety concerns such as patients at high risk of falls and pressure ulcers. This was based on, “The Yorkshire Safety Huddle;” a project published by the Health Foundation/University of Bradford in 2013.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. They developed individual care plans for patients and provided snacks and nutritional supplements to encourage them to eat. They used special feeding and hydration techniques when appropriate.
Staff assessed patient’s nutrition and hydration needs using the malnutrition universal screening tool (MUST) and supplemented this with a more detailed assessment of each patient’s nutrition and hydration support needs. Care plans were in place to ensure patients received appropriate support and nutrition.

A care plan we reviewed showed that a patient was referred to the dietitian for advice when nutritional issues, such as weight loss, or low appetite gave cause for concern. We also saw that a specialist nurse identified the need for a person to receive enteral feeding (tube feeding) on an oncology ward and took steps to address this in the short term and initiated plans for a longer term solution.

The individual end of life care plan prompted staff to review patient’s nutrition and hydration status and the two care plans we reviewed were fully completed. There were clear instructions for staff on how to support the person in each case.

The ward manager had introduced snack trolleys in each patient bay which enabled patients to free access to nutritional supplement drinks and a selection of crisps, cereal and snack bars, and other pre-packaged snacks. This was important in maintaining the nutritional intake of people whose appetite might be affected.

We observed each patient had a water jug, beakers/glasses and drinks, all within easy reach.

**Pain relief**

The service managed patient’s pain and other symptoms well. The effectiveness of pain relieving medicines was monitored, reviewed and adjusted accordingly.

All staff had access to guidelines on the management of pain in end of life care, including an anticipatory drugs prescribing policy and syringe pump policy on the intranet.

Staff documented pain assessments in patients’ care records and we saw evidence of this in all of the records we reviewed.

We reviewed a record of a patient whose pain was being controlled using a syringe pump. There was a comprehensive assessment of the person’s pain and the decision making process. Additional medicines were prescribed to be given as needed.

Care records demonstrated the effectiveness of pain relieving medicines were monitored and reviewed and their medicines adjusted to maximise their effect.

Four patients we spoke with about their pain, told us their pain was managed effectively. One person said that when they were admitted to the ward they had severe pain, constipation, nausea and vomiting and no appetite. They said that within two days their pain was controlled, their vomiting was addressed and within four days had resolved completely. As a result their appetite had returned and they had gained weight. They said, “You only have to ask and pain relief is given promptly.” Another patient said, “You often don’t have to ask for pain relief; they (nurses) check on how you are doing and can tell from the expression on your face that you are in pain, and they offer you pain relief.” They went on to say, “They are getting on top of my pain. It is a gradual process, as they tweak it until they find the most effective combination.”
Patient outcomes

Effectiveness of care and treatment was monitored and findings were used to improve them.

End of life care Audit: Dying in Hospital
The trust participated in the end of life care audit: Dying in Hospital 2016 and performed better than the England average for four of the five clinical indicators. The trust scored particularly well compared to the England average for the following indicators:

- Is there documented evidence that the needs of the person(s) important to the patient were asked about? (Trust: 80%, England average: 56%)
- Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care? (Trust: 76%, England average: 66%)

The trust answered yes to all of the eight organisational indicators indicating compliance with the standards.

(Source: Royal College of Physicians)

The trust completed a gap analysis to identify the actions required to address areas for improvement identified in the audit. We saw that they had made considerable progress against the action plan with most areas of work complete.

MSH was working towards external independent accreditation as part of the Cancer Centre wide radiology accreditation process, as some patients in the MVCC.

The service was implementing the use of I-POS (integrated palliative care outcome score) as a means of measuring outcomes for patients attending the service. The I-POS measures were specifically developed for use among people severely affected by diseases such as cancer, respiratory, heart, renal or liver failure, and neurological diseases. Consultants we spoke with described this as a ‘work in progress. I-POS scores were completed for a patient when they were referred to the service and it was repeated later in their treatment process. At the time of our inspection, medical staff used the score to assess changes to the individual patient over time and did not collate the information for benchmarking purposes but this was an ultimate goal.

Competent staff

Staff were competent for their roles. Managers appraised staffs’ work performance and held supervision meetings with them to provide support and monitor their effectiveness.

The service employed a lecturer practitioner (0.6WTE) to provide training for staff in end of life care and to provide mentorship and support to staff. They showed us copies of their training programme which consisted one full day’s training on the five priorities for end of life care and short ward based sessions on particular topics such as chemotherapy, managing neutropenic sepsis,
and different aspects of symptom control. They also worked on the inpatient ward at MSH with staff nurses, bank nurses and student nurses.

Approximately half of the staff on the inpatient ward had attended the full day training in the last year in addition to the ward based sessions. Records of staff attending the ward based sessions were not initially entered onto a database and therefore it was not possible to view these. We were told a process for this was being developed. We reviewed evaluations from the training during the inspection and they were all very positive. Staff indicated their knowledge had increased as a result of attendance.

Nurses attended syringe pump training and completed a competency assessment prior to administering medicines in a syringe pump. The trust did not have a requirement for staff to attend update or refresher training, but staff were able to attend the training again if they wished. As registered nurses they were considered to be accountable to ensure they maintained their skills.

Some of the clinical nurse specialists were able to prescribe medicines and received support and supervision to enable them to work safely and effectively in this role.

All staff including volunteers completed communication skills training specifically tailored to end of life care.

Nursing staff told us they had access to training and were able to ask if they required additional training. A student nurse said they had received a good induction, had attended study sessions on essential symptom control and medicines management and were supported in achieving their competencies for training. They felt there was excellent support and education for student nurses.

Junior medical staff in MVCC (including MSH) said the consultants provided teaching on the ward and they were able to access their regular training sessions.

Nursing staff had the opportunity to attend monthly clinical supervision or reflective practice sessions. Staff told us they found the sessions helpful and they all commented on the excellent peer support they received in their areas.

A member of staff told us that ‘Schwartz rounds’ were held bimonthly which all staff could attend. These are group reflective practice forums which provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work without discussing individual cases.

Volunteers were recruited to a range of roles in MSH including providing support at mealtimes and with refreshments and maintaining the gardens, tropical fish and the aviary. Some volunteers with the appropriate professional qualifications also provided bereavement counselling, facilitated support groups and provided complementary therapies. They were managed by the community engagement manager and volunteer coordinators. Their qualifications were checked during the recruitment process and they received a full induction to their role including communication skills.

**Appraisal rates**
From April 2017 to October 2017, 95% of staff within end of life care at Mount Vernon Cancer Centre had received an appraisal compared to a trust target of 90%. There was no appraisal information included about medical staff.

A split by staff group can be seen in the table below:
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Medical and nursing staff we spoke with confirmed they had an annual appraisal which they found constructive and supportive.

The trust provided access to a computerised system for medical staff to record the evidence they needed for re-validation.

**Multidisciplinary working**

Staff from different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We saw excellent examples of multi-disciplinary team (MDT) working. A daily multi-disciplinary hand over meeting was held at 9am each morning which was attended by all professional groups including doctors, nurses, allied health professionals, community nursing representatives, the patient and family support service, and chaplain. We observed this meeting and saw all staff were able to contribute and there was effective discussion about the care and support of patients. A member of staff said, “The handover each day is a mini MDT. We value everyone’s skills.”
There were weekly palliative care MDT meetings and fortnightly MDT meetings for patients attending the day centre. Medical staff worked closely with the oncologists where patients continued to receive palliative treatments such as chemotherapy and they were clear as to who had the overall responsibility for each patient.

When patients required referral to community nursing services staff had a central email address to send the referrals to. They followed this up with a telephone call and said the system had improved since the introduction of a central email address.

Patient records demonstrated the input of a range of different professionals into the patient’s care. The trust had access to a large number of volunteers coordinated by the community engagement manager who was funded by charity. There were approximately 90 volunteers who contributed their time in MSH. Volunteers worked in a variety of roles including assisting with meals and serving drinks, maintaining the garden, caring for the aviary, and fishes. There were also volunteer bereavement counsellors, and complementary therapists. There were clear arrangements for the management of the volunteers and job descriptions for each role.

Seven-day services

The service was working towards providing seven day services.

Junior medical staff were rostered on the in-patient ward at MSH between 9am and 5pm, Monday to Friday. Outside these hours there was on-call access to junior doctors.

All patients were reviewed by a junior doctor daily.

A named palliative care consultant was available on site Monday to Friday between 9am and 5pm. A consultant led ward round was undertaken on Tuesdays and Fridays and there was a MDT meeting on Mondays.

There was a consultant on call service during the evenings and weekends, which was shared with colleagues from a neighbouring hospice. Telephone advice was also provided to four hospitals by the consultant on call.

The day centre operated weekdays. Mondays was reserved for carers to attend and on Tuesdays patients attended for medical procedures such as intravenous infusions. From Wednesday to Friday patients attended for counselling, support, advice, information and complimentary therapies. They were reviewed by nurses and were able to see a consultant if necessary.

Health promotion

Complementary therapies were offered for patients attending the day centre. This included aromatherapy, Indian head massage, reflexology and Reiki. The operational policy for the day centre gave clear criteria for patients who could be safely offered each therapy.

There was also access to creative arts through the day centre. Art groups were held on Wednesday, Thursday and Friday. The creative arts lead was funded by a charity. They offered a range of arts and crafts activities to increase well-being and a sense of achievement.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act (2005). They knew how to support patients those who lacked the capacity to make decisions about their care.

At the inspection in October 2015 we identified that staff did not always obtain or record consent in line with relevant guidance and legislation. There was a lack of consistency in how people’s mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation. At this inspection these issues had been addressed.

Medical staff were aware of the need to obtain consent for care and treatment and spoke with us about the steps they took to seek patients’ views and discuss treatment options with them. Prior to the decision that someone was to move to end of life care, they had discussions with patients and provided information over a period of time to give the patient and their relatives time to absorb the information and make decision about what they wanted.

The five DNACPR forms we reviewed were completed appropriately and gave information about the discussions held with the patient and their relatives.

Six snapshot audits had been completed during 2017 to review the completion of DNACPR forms on the in-patients wards at MVCC (Wards 10 and 11 and MSH.) The audit indicated that most forms were fully and appropriately completed. The area where there was an occasional omission was in the review and endorsement of the form by a Consultant within 72 hours of the form being completed. The matron for wards 10 and 11 at MVCC was identified to follow up on action to improve over the next six months.

Medical staff we spoke with were knowledgeable about the Mental Capacity Act (2005) and the implications for their practice. When patients were unable to make a decision for themselves they said they always checked whether the patient had an advanced decision to refuse treatment, or whether a lasting power of attorney for health and welfare was in place. They were knowledgeable about the need to use an independent mental capacity advocate in best interest decisions if the person was unable to make a decision for themselves and did not have any relatives or informal carers who could be consulted about the person’s wishes.

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. However, the trust did not provide any data relating to Mental Capacity Act and Deprivation of Liberty Safeguards training completion.

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

Following the inspection, the trust provided details of the number of staff in MSH that had completed training. This showed that 10 staff completed training in the Mental Capacity Act (2005) during October 2016. This equated to approximately 30% of staff.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Patients and their relatives said they could not praise staff highly enough for their care and understanding.

During the inspection we saw numerous examples of staff and volunteers’ kindness and compassion for patients. They noticed when a patient was looking unsure and asked if they needed help and offered to sit with them. They created a pleasant, cheerful and relaxed atmosphere and spoke positively with patients. A patient said, “You can talk to them and have a laugh. That’s really important. They have so much empathy and they do a hard job.”

Patients talked about nothing being too much trouble for staff and staff being very attentive to their needs.

We saw examples of thoughtful touches which made a difference to people. For example, a person’s neck was painful and staff moved their bed round at right angles to the norm, to enable them to see out of the window to look at the scenery and wildlife.

Staff spoke about patients with respect and professionalism, and with warmth and understanding for their situation. A housekeeper said they always liked to chat with visitors to make them feel comfortable.

Patients attending the day centre praised all the staff highly, including the drivers and volunteers.

We reviewed patients’ care records and saw notes made by staff were respectful and considerate of the patient and their families.

There was a ‘memory book’ in the multi faith room, which contained messages written on behalf of bereaved relatives.

A bereaved carer’s survey was completed and reported in December 2016. This was completed by 19 carers of patients attending MSH. The survey showed a high level of satisfaction with the care provided from the palliative care team in all aspects of care from the way the patient’s condition and likely progress was explained to respect for privacy and dignity and emotional support for the patient and family.

The in-patient ward achieved a response rate above the national average in the national Friends and Family Test (FFT) survey. From March 2017 to February 2018, 100% of those participating would recommend the ward to their family and friends.

Emotional support

Staff provided emotional support to patients to minimise their distress. A range of emotional support was available to patients and their families.

Staff within the wards and day centre provided ongoing emotional support and patients commented on the high levels of support they received from staff on a day to day basis.
On the day the inspection team visited the day centre, staff told us that a patient who attended regularly had died in the past week. Staff explained they would inform the other patients who would be asking about the person, and give them opportunities to talk with staff and counsellors through the course of the day if they wished.

In addition, the Patient and Family Support team (PAFS) visited patients and offered their support in the in-patient ward and the day centre. They made themselves available within the wards and communal areas and people could chat with them in those areas or privately if they wished. They attended handover so were aware of each person’s progress, enabling them to be sensitive to the person’s situation. The PAFS staff were qualified and accredited counsellors.

A patient told us they were offered input from the PAFS team and had an initial chat with them. They also commented on the emotional support the nurses provided. They said, “They look at you and know when you are down and they will talk with you.” They also mentioned that when they had received some bad news, their partner was able to stay overnight by their bed. They said staff had offered to provide a bed but they had wanted to stay close to their relative and their partner had stayed on a recliner chair by their bed.

Bereavement support was offered to the main contact for patients of MSH approximately eight weeks after a patient’s death. They offered up to six sessions of counselling spread over a period of time or telephone support.

The trust had a spiritual and pastoral care team with representation from different faiths and supported by volunteers. They told us there was normally a person on site each weekday and there was an on-call system to enable patients to be seen out of hours. There was a multi-faith room in MSH and a chapel and prayer room at the front of the Mount Vernon Hospital.

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

**Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families were aware of the plans for their care and were involved in decision making at every step.**

Care records we reviewed contained detailed information about discussions staff had with patients and their families on a regular basis. This included discussions about the patient’s wishes and who they wanted to be included in discussions.

Patients we spoke with were aware of the plans for their care and the next steps for them. For example, a patient told us they were awaiting a nursing home placement and another talked about the plan for them going home with support from community staff.

A patient said they were having a progress meeting that afternoon. They said, “Every week they ask how you are doing. I am able to control the decisions; I tell them what I want.” Another patient said, “Everything is explained clearly.” They said no changes were made to their management without discussion with them first.

The bereaved carer’s survey reported at the end of 2016 showed high levels of satisfaction with the involvement of family in treatment and care decisions (84% were very satisfied and the question was not applicable for 16%), along with meetings with the palliative care team to discuss the patient’s condition (84% very satisfied, 16% not applicable).
**Is the service responsive?**

**Service delivery to meet the needs of local people**

Staff responded to demand for the service but there were difficulties with engagement with stakeholders which made forward planning difficult. The environment within the inpatient unit in particular, was not well adapted to the needs of people using it.

Consultants had developed good relationships with GPs in the local area and held a number of events which GPs attended. For example, they had an annual study day for GP trainees which many of the local GPs also attended. A consultant had developed a journal club which colleagues from the local NHS trust also attended.

Consultants we spoke with said they found it difficult to build up relationships with commissioners as they admitted patients from a wide geographical area which covered a number of different clinical commissioning groups. This made it difficult to take the service forward and gain required funding for developments.

Data provided by the trust confirmed patients attended or were admitted to MSH from a wide geographical area. The majority of patients were from Hertfordshire, Hillingdon and Harrow, but there were a minority of patients from Barnet, Buckinghamshire, Ealing and the Chilterns.

The community liaison nurse specialist who coordinated admissions to MSH said they worked closely with the Hertfordshire palliative care referral centre to accept referrals and ensure patients were offered a bed in the most appropriate service. They also accepted referral from other areas. The service accepted referrals for patients with a range of life limiting conditions but as the service was part of the MVCC, the majority of patients had a cancer diagnosis.

The service had strong links with the Friends of MSH, which funded many of the staff posts within the service.

The environment of MSH did not provide the type of environment usually associated with a hospice. Staff had done their best to provide a range of areas for patients and visitors to spend time, but the ward in particular was not well adapted for the use of patients at the end of their life and facilities were basic. There were no toilets with disabled access or adaptations for people with mobility issues such as grab rails. However, there was an open lounge and dining area close to the entrance with a television and games for children. From this there was access to a beautifully maintained garden area with seating which provided a quiet contemplative space for people to relax. This area and an aviary were maintained by volunteers.

The in-patient ward provided care in four bedded bays and side rooms. These were poorly maintained and some rooms could not be used. For example, one room had a non-functioning shower. This meant that the opportunities for patients at the end of their life who wished to have privacy were restricted.

Staff adhered to the requirements of same sex accommodation as far as it was possible within the footprint of the ward. Patients were cared for in single sex bays but we observed a male patient being supported with mobility by physiotherapists using a piece of equipment sited in a female bay. In addition, there was one bathroom for patients who needed to use a stretcher bath and the other was an adapted bath for use by patients who were able to sit. These were the only bathing facilities on the ward and were used by males and females.
The day centre had a mix of communal areas including a creative arts and crafts room and sitting area. There were individual consulting rooms for medical and nursing staff and rooms for complimentary therapies. There was a hairdressing salon, but this could not be used as the wash basin was cracked and the surround was damaged.

Meeting people’s individual needs

Patients’ individual needs were accounted for. Staff delivered care in a way that took account of the needs of different people on the grounds of age, disability, gender, race, religion or belief and sexual orientation.

The service used a systematic approach to assessing and planning care and utilised the framework in a way which took into account each person’s individual needs. We saw detailed information about the person’s individual symptoms and situation in patient’s care records and evidence that these were used when planning care.

Staff told us they were able to access interpreting and translation services through the trust switchboard. They said they were normally booked in advance but could access them at short notice if necessary. The trust told us they had access to a telephone translation service but staff did not mention this when asked about patients who were unable to speak English.

The in-patient ward and day centre had a ‘Hospital Communication Handbook’ which provided pictorial images to aid communication with people who had difficulties with the written word. Staff told us they encouraged carers to be involved and support patients particularly when they had complex needs.

The chaplaincy provided access to multi-faith advisors and there was a multi-faith room in MSH. The multi faith room was open and accessible to all, 24 hours seven days a week. It was equipped with multi-faith items including prayer mats and prayer books. Family and carers used the room to view their recently deceased relatives or as a space to have time to themselves.

Staff were aware of the adjustments which might be needed when caring for people living with dementia although the environment was not adapted to meet the needs of people living with dementia. The community liaison nurse manager was the dementia link nurse and provided support and advice to staff.

Patients we spoke with gave us mixed feedback on the quality of food provided. One patient told us the food was very variable and on some days it was unpalatable and they couldn’t eat it. Staff in MSH told us that one of the regular issues raised by patients in patient experience feedback related to the quality of the food. They said they reported this back to the supplier but with little effect. As a result, snacks and soups were stocked within MSH. MSH scored 99% for food in the 2017 PLACE audit.

There was open visiting. Staff and relatives told us that relatives could come at any time of the day or night to visit their relative and stay as long as they wanted. Staff ensured that relatives had access to food and drinks 24 hours a day whilst they were visiting.

Staff told us of ways they tried to fulfil patients’ wishes at the end of their life. A member of staff said they had had a patient who wanted to go to a particular foreign country, but was not well
enough. They said they had a day which reflected that county’s culture, decorated the summer house, playing particular music providing food and that was reflective of that country and generally trying to create an enjoyable experience for the patient. Staff also told us that a patient wanted to see their children play football but was not well enough to attend their football match. However, they took the patient’s bed into the garden to enable them to watch them play football there.

**Access and flow**

**People could not always access the service, when they needed it. The service was not always able to respond when people required urgent admission. Nursing and medical staffing levels impacted on the service’s ability to admit patients after 3pm and at weekends.**

At the inspection in October 2015 the trust was not monitoring referrals to MSH. At this inspection we found staff were monitoring referrals but the service could only accept a proportion of these.

The trust had clear criteria for admission of patients to the in-patient ward at MSH. The community liaison nurse manager triaged referrals using a RAG (red, amber, green) rating system. However, it was not always possible to admit patients with the highest RAG rating.

Data provided by the trust indicated that from January 2017 to December 2017 there were 567 referrals to the inpatient unit at MSH. Of these 296 were admitted.

The trust audited the number of referrals to the in-patient unit from July 2017 to October 2017. In this period there were 197 referrals and 85 patients were admitted. There were a number of reasons why patients were not admitted in addition to bed capacity issues. The audit results provided to us did not quantify the number of patients in each category and therefore it was not clear how this audit data was utilised.

Some of these patients were also referred to other hospices or facilities in the area. In addition, some of those referred no longer required a bed when it was offered as patients’ conditions changed rapidly.

Staff told us they limited admissions to between two and three people per day and did not normally admit patients after 3pm in the afternoon as they needed time to complete a full assessment of the patient and nurse and medical staffing was not sufficient to admit more patients.

The trust reported that bed occupancy for the in-patient ward at MSH was 71% over a 12 month period and patients had an average length of stay of 11 days. This meant the bed capacity was not utilised as effectively as possible.

Staff told us that when patients required a rapid discharge home, they worked with staff in the community to achieve this. Policies for this had been developed within the six months leading up to the inspection. The trust had not completed any audits of fast track discharge or rapid discharge of patients at the end of their life at MVCC. Therefore they were uncertain as to the effectiveness of the process and did not have a baseline from which to assess improvements. However, the work plan for the end of life strategy group contained a plan to audit the process in September 2018.

Data from an audit completed by the trust indicated that of 179 deaths in end of life care, which occurred between January 2017 and December 2018, 81% achieved their preferred place of
death. The work plan for the end of life strategy group did not identify this as an area for improvement.

The day centre provided 14 chairs but additional patients could be accommodated on occasions when necessary. There was an operational policy and clear criteria for referrals. Patients were referred by a health professional; patients could not self-refer. Patients were offered up to twelve weeks attendance at the day centre. A pre-assessment was completed by nurses, medical staff and allied health professional to ensure the services offered could benefit the patient. Goals were set within the pre-assessment process and re-visited at intervals during the course of their visits.

Learning from complaints and concerns

Summary of complaints
From November 2016 to November 2017 there were no complaints about end of life care at MSH.
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Patients we spoke with said they did not have any reason to make a complaint but said they would speak to the nurse in charge if they had a concern or complaint.

Patient information leaflets entitled, ‘Comments, Compliments, Concerns, Complaints,’ were available in the foyer of MSH. This provided information about the Patient Advice and Liaison Service (PALS) and information on how to make a complaint. It also provided sign posting to the Independent Complaints Advisory Service and Healthwatch.

We saw numerous letters and cards of thanks from patients and relatives.

Is the service well-led?

Leadership

Although there were some improvements in the leadership of end of life services in the trust since the inspection in 2015, leaders had not overcome all the challenges posed by the delivery of the service at the MVCC site.

End of life care services at the trust sat within the cancer division of the trust. The cancer division was led by a divisional chair, divisional director and newly appointed head of nursing. The divisional leads were all based at MVCC. At MSH the local leadership team for end of life care services consisted of a lead consultant and a head of palliative care. The head of palliative care was on site at MSH three days per week. The trust’s end of life clinical lead was based at the Lister hospital and supported the MVCC clinical lead.

A non-executive director had recently taken the lead for end of life care.

Nursing staff felt well supported by their ward manager and the day centre manager and in the same way these managers were supported by the head of palliative care.
The distance between the Lister hospital and MVCC presented some challenges for the leadership and management of services. A consultant said, “Senior managers are aware of this site but we don’t see them very much. However, we see the current team more than previously.”

We witnessed one of the challenges for the team. On the first day of our inspection a meeting was due to be held at the Lister hospital with a video link to MSH, but the link could not be established and the meeting went ahead separately at each site. Later we were told that the meeting did not take place at MSH and all the key people were at the Lister site.

Some staff expressed the view that the senior managers lacked an awareness of the issues at MSH and did not understand the complexity of the service. They felt they were out of touch with the end of life service at MSH which all agreed was very different to the service at the Lister hospital. However, others felt MSH was given more priority by the trust than previously. They told us the appointment of non-executive director lead for end of life services was very positive and they found them very supportive.

The buildings of the MVCC were owned by another NHS trust and previously the staff had found difficulties in taking forward issues related to maintenance of the buildings and environment. However, staff said that the non-executive director had made considerable efforts to engage with the senior managers at the Hillingdon trust and they were now more responsive when issues were reported. A member of staff said, “Dialogue is better now and discussions between the two trusts are better.” They said they now had a log of maintenance issues and they were able to better manage the contract for cleaning and housekeeping services.

However, staff continued to be concerned about the future of the end of life service at MSH and the configuration of services. Some staff felt that the trust didn’t appreciate the challenges of providing a service to patients outside their normal geographical area. This was particularly an issue, as a large proportion of admissions to the in-patient ward and the majority of day centre attenders were from outside Hertfordshire.

Data provided by the trust indicated that from January 2017 to December 2017, 55% of referrals to the in-patient ward were from outside Hertfordshire (mostly Hillingdon and Harrow). Trust data indicated 78% of day hospice attenders were not from Hertfordshire.

There were major differences between the views of the senior management team and the staff at MSH about the future direction of the service and its configuration. We were told a meeting had been held the previous week to discuss a forthcoming reconfiguration of the service. Whilst staff told us the proposed re-configuration had been suggested to them, they told us they understood that the first choice of action was in a totally different direction than the one described to us by senior managers. As a result, we had concerns about the trust’s approach to the management of change and communication between the staff and managers from the different sites.

Vision and strategy

Although the service had an end of life care strategy group, and an updated trust wide draft end of life strategy for adults for 2018 -2021 had been developed, staff at MSH had a different view as to the most appropriate direction for the management and delivery of end of life care at the MVCC. There was a lack of ownership of the strategy.
The trust had an end of life care strategy group and an updated trust wide draft end of life strategy for adults for 2018 -2021 had been developed. There was also a work plan which we were told were based on the priorities for end of life care and the actions from the CQC inspection in 2015. We reviewed the strategy and found it identified key national guidance documents and was based on the six ambitions for palliative and end of life care published by the National Palliative and End of Life Care Partnership (2015). It provided some broad objectives under each ambition but it did not provide specific information of how these would be realised within the services provided by the trust. There was no vision of the future configuration of services and no site-specific information. A member of staff said, “The problem with the strategy is that it doesn’t say how we are going to provide the care.”

The group had a work plan and this provided information on the key priorities in the implementation of the strategy. It identified the systems and processes which were to be developed to ensure practice was evidence based, there was optimal management of patient care and outcomes for patients, and to gain feedback on patient and family experience. It did not suggest there would be any consideration given to the configuration of the services and how they would be delivered in practical terms.

The agenda for the end of life care strategy group which was due to take place during our inspection, contained discussion of a new treatment escalation plan, information about end of life care audits and risk management. Although the draft strategy and work plan were on the agenda for discussion, it was agreed to send the strategy out for electronic consultation and the work plan was not discussed. Therefore, there was no discussion of progress in relation to the strategy at the meeting.

Senior managers told us the meetings took place at the Lister hospital as 75% of the staff were based at the Lister hospital. We reviewed the terms of reference for the group and saw that whilst there was broad representation from within the trust, there was no representation from external stakeholders such as commissioners or the public. Senior managers told us they were members of the East and North Hertfordshire CCG strategy group and managers from MVCC attended the Hillingdon end of life forum.

From our discussions with staff, it was clear that staff on the ground had a different view as to the most appropriate direction for the management and delivery of end of life care at the MVCC site to that of senior managers and there was a lack of ownership of the strategy. A member of staff said, “The trust wide strategy is acute focused; we just get on with it down here.” They went on to say the site issues were not obvious in the strategy.

When we discussed some of the issues with the differing views of the strategy and the diversity of opinion as to the way forward at MVCC, senior managers said they were going to develop site specific strategies to underpin the trust wide strategy.

At the inspection in 2015 we found similar issues in relation to the strategy and we found little progress had been made since then.

**Culture**

*Staff felt valued and respected within Michael Sobell House.*
There was a culture in which the well-being of patients was central for staff. On a day to day basis staff were very focused on how they could improve patients’ lives and help them to achieve what was important to them.

The multi-professional team worked together to achieve this and were each perceived as having an equal and important role to play. A member of staff said, “It feels as though we are separate from the rest of the trust, but we don’t feel isolated as we are a big family down here and it has a very nice feel about it”.

Staff felt valued and respected within MSH but they did not feel the rest of the trust understood their service.

A member of staff said that it felt quite old fashioned at times as the service was still using paper records and the different computer systems did not communicate with each other so part of the role were labour intensive.

**Governance**

*The arrangements for clinical governance were not fully clear or robust. The reporting structure was unclear and although there was some discussion of incidents, risks, complaints and patient feedback at the end of life care clinical governance group, information was sometimes missing and escalation of issues was unclear.*

The trust provided us with a flow chart to demonstrate the reporting structure for clinical governance for end of life care. The supporting narrative provided indicated that clinical governance issues were discussed at quarterly specialist palliative care clinical governance meetings and cross cutting issues were discussed at the quarterly end of life care strategy group. The specialist palliative care governance group reported to the cancer divisional board which in turn reported to the trust risk and quality committee and the end of life strategy group reported directly to the trust risk and quality committee. Managers also talked about a MVCC clinical governance group, which we were told the MSH clinical governance group reported to. Due to the fact that staff did not use the same name for committees as was on the structure we were provided with, and the structure did not have the same titles for groups as was on the minutes of meetings, it was difficult to determine which committee was being referred to.

The trust provided us with the minutes of monthly MVCC clinical governance oversight meetings; however, the structure for clinical governance provided by the trust did not identify this committee. Minutes of these showed a discussion of financial issues occurred at each meeting and there were updates from specific areas within MVCC on their current challenges. There was no discussion of clinical quality, patient safety or patient experience. We did not see any evidence of discussion of any issues related to MSH. We were also told the MVCC had weekly clinical governance meetings and end of life care services was represented at these meetings. However, the trust did not provide us with minutes of these meetings.

We were provided with the minutes of two MSH clinical governance meetings (presumably the specialist palliative care governance group). These did show some discussion of incidents, risks, complaints and patient feedback, but data on quality indicators was not always available and the discussion did not include any reference to some of the key quality indicators such as hand hygiene compliance not being collected regularly.
We did not see escalation of issues relating to clinical quality and governance in end of life care being escalated within the governance framework.

Staff gave us examples of measures taken to reduce falls and medication errors as a result of analysis of incidents. However, there was little awareness or learning from incidents outside MSH. We therefore could not be assured of the flow of information through the organisation.

Managers told us clinical governance issues for MSH were escalated through the divisional senior management meeting and the cancer centre clinical governance group, but the flow of information was unclear. We reviewed the minutes of three MVCC clinical governance overview meetings and did not see any evidence of discussion of any issues related to MSH.

The trust had service level agreements with the host trust for the maintenance of the site, for housekeeping services, and for mortuary services. There had been some issues with obtaining the agreed levels of service for these but staff told us they were now more rigorously managed and the levels of service had improved. They gave examples of maintenance work being carried out and improved response times when deep cleaning of areas was required.

Management of risk, issues and performance

The service did not have consistently effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks to the service were not always identified or progressed.

However, the managers were aware of the risk the environment at Michael Sobell House posed to patients care and had undertaken risk assessments. In addition, the plan to provide the service a different environment was being expedited.

The senior management team told us the top risks for end of life care were patients not on the end of life pathway and therefore possibly not receiving optimal care, a lack of access to the Electronic palliative care coordination system (EPACCS) and medical staffing.

They said the risk register for end of life care was a subset of the cancer services risk register. The divisional risk register detailed that patient care was compromised due to poor fabric of the estate at MVCC. This was rated at 20. There were a number of actions, as well as a plan to relocate the service.

We reviewed the risk register for the MVCC site. It contained a range of risks including staffing issues, equipment and information systems. However, some of the risks on the risk register had not been updated or reviewed since 2016. Issues relating to the environment on the Mount Vernon site generally were identified. These included issues with asbestos, water safety, the poor condition of the fabric of the buildings and inability to carry out statutory planned preventative maintenance due to staffing issues.

A risk on the risk register relating to MSH specifically was inadequate cleaning and we saw this had been addressed through the provision of additional hours for housekeeping staff. Staffing levels at night were identified as being an issue for the MVCC site generally, which resulted in a lack of flexibility to transfer staff to cover short notice sickness or absence. Concerns discussed with us about the sufficiency of planned staffing levels at night in MSH were not included.
The trust provided a risk register for end of life care which had been reviewed following our inspection visit. It did not show the dates the risks were added to the risk register so it was not possible to assess whether some of the risks identified were on the risk register prior to the inspection. We had been told the end of life risk register was a subset of the cancer services risk register but this did not appear to the case as the risks on the end of life care risk register were not on the MVCC risk register. However, the end of life care risk register identified risks the senior management team had discussed with us. We noted the environment was not on this register. Initial maintenance work to improve the environment of MSH had been completed but the environment continued to pose a risk for the future delivery of services.

A major risk to the sustainability of end of life services was a sudden fall in charitable funding due to the number of posts funded from charitable sources. This was not on the risk register. We were told that all the clinical support worker posts were funded from charity and many of the posts such as the patient and family support service and bereavement service were funded from the charity. Managers told us they had recently been advised that the annual funding from the charity would be reduced from £895,000 to £525,000 in the new financial year due to reduced charitable donations. We did not find anyone who had a formulated plan for dealing with this.

There were no mortuary facilities within the footprint of the MVCC and there were no facilities for keeping deceased patients on site for more than 24 hours. The trust had an informal agreement with the trust owning the Mount Vernon site to enable them to use the Mount Vernon hospital mortuary but there was no formal service level agreement. The risk associated with the lack of a mortuary within the MVCC site was identified on the risk register but not the risk related to the fact there was no formal service level agreement with the Mount Vernon hospital mortuary.

The service had secured short term charitable funding for six months to provide medical cover for the day centre on Fridays to enable a wider range of patients to access the day centre and bring the service in line with that offered on other days of the week. Medical staff said they were going back to the charity to ask for a continuation of the finding. However, given the limitations of the charitable funding identified above, it was unlikely this would be successful. Staff did not feel it was likely that a business case to the trust would be successful as they did not feel the day centre was seen as a priority. This was indicative of the lack of confidence of staff about the motivation of the senior management team to prioritise the service at MSH.

Information management

The trust had a set of nursing quality indicators which were measured monthly and the head of end of life care reported on these through the clinical governance committee. These contained data on staffing, a range of patient safety measures and patient experience. We saw compliance against trust targets was good when the audits were completed. However, we found some audits were not completed as required. For example, from March 2017 to February 2018, hand hygiene audits, audits of patient identification and medicines audits were only completed irregularly and on only five or six months of the year. There was no evidence this had been identified or addressed.

The service also reported on the number and percentage of patients who died who were on the individual end of life pathway and this showed some improvement over the last year.

The end of life service at MVCC had access to an electronic end of life coordination system (Coordinate my Care) for patients from Hillingdon. This meant information was available to staff
across the area about decisions made and each patient’s care and treatment. An audit was completed within the service which indicated the information on this system was accurate and up to date.

However, staff did not have access to a similar system for patients in Hertfordshire and other areas. As a result, coordination of care between difference services was more difficult.

Medical staff told us they found navigating the trust computerised information systems clumsy, time consuming and inefficient. One person gave us an example of discharge summaries which were written in one system and transferred to others. However, senior managers told us that all discharge summaries were completed on the new patient administration system and were not transferred.

**Engagement**

**Managers did not engage well with patients, staff or the public to plan and manage appropriate services.**

The end of life clinical governance group had a user representative but we did not find other examples of patient or public representation on service development or quality improvement groups. Managers said they intended to engage with patients and the public when they developed the end of life strategy for each site.

Managers said they had consulted with the local ambulance service in relation to the treatment escalation plan for end of life patients as this included the transfer of patients to other sites.

The trust monitored eight aspects of patient experience, including support to eat meals, response to call bells, staffing levels, pain control and emotional support from staff, on a monthly basis for in-patient wards. The in-patient ward at MSH scored 98% or above for all measures from March 2017 to February 2018.

Staff were passionate about the service and care they provided, but the issues we identified and described in this report under leadership and vision and strategy indicated issues about the way managers and staff engaged in the development of the service.

Staff did not feel actively engaged or empowered to resolve issues and did not feel they were always taken seriously or listened to when they raised issues. They told us they had reported issues relating to the development of the service, funding and the environment and these were not resolved.

Results from the NHS staff survey for 2017, showed a fall in staff satisfaction in most areas of the survey. In particular:

- The extent to which staff felt senior managers tried to involve them in important decisions,
- Whether senior managers acted on their feedback
- The effectiveness of communication between senior managers and staff
- The ability to make improvements happen in their area of work.

Although the above are the results of a trust wide survey and not specific to staff in end of life care, they are reflective of the feedback we received from staff we spoke with in end of life care.
Staff felt senior managers did not fully understand the issues related to end of life care at MVCC or they felt that it was not seen as a priority. Our discussions with senior managers and staff also indicated a lack of engagement between senior managers and staff in identifying a clear way forward for the service.

**Learning, continuous improvement and innovation**

The service was participating in an enhanced supportive care pilot project. This project was to provide access to specialist services to support patients and families early in the palliative care process, for patients whose cancer was incurable but who may still be continuing to receive treatment. They provided advice on symptom control, sign posted people to other services and advanced care planning when appropriate. The service was within the second year of a three year pilot project. Managers told us they planned to make a business case for expansion and continuation.

A consultant was completing a master’s degree in education and as part of this had completed projects to enhance learning in the clinical environment of the hospice. They had published research looking at near peer review on consultant ward rounds and were undertaking a project to look at junior doctor learning opportunities and challenges in the hospice.
Chemotherapy

Facts and data about this service

The trust provides a chemotherapy service at the Mount Vernon Cancer Centre.

Patients from all tumour groups, including those on clinical trials, are treated in the cancer centre’s chemotherapy outpatients suite where they receive both simple and complex cytotoxic drug regimens and targeted therapies.

The chemotherapy suite is open Monday to Friday, treating an average of 40 patients per day. It has 21 treatment chairs and two beds. Side rooms are available for patients to be seen on a one-to-one basis by the unit’s doctors or nurses.

(Source: Trust website)

There is a ‘supportive care unit’ at the Mount Vernon Cancer Centre. This is a new day case service for patients requiring assessment, monitoring or treatment for cancer treatment or disease related problems. There are three beds and nine treatment chairs in the unit and a day case designated research unit. Short duration Systemic Anti-Cancer Therapy treatments are administered at this unit. It also accommodates Mount Vernon’s clinical trials.

Is the service safe?

Mandatory training

The service provided mandatory training in key subjects to all staff and made sure everyone completed it.

In addition to the listed mandatory training module subjects, the staff underwent annual chemotherapy training that was deemed mandatory for maintaining competence in this specialised area. This was taken seriously. For example, a member of the team had failed to attend the training following two warnings. This meant that the staff member was unable to administer chemotherapy until attending the training. They were booked on to the next study day.

Overall mandatory training rates

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

The trust set a target of 90% for completion of mandatory training.
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<th>Completion rate</th>
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Overall completion rate for nursing staff was 94% (February 2018).
(Source: additional data request).

**Safeguarding**

Staff we spoke with were aware of the signs of potential abuse and the different types of abuse. They described their training and understood how to raise concerns.

**Safeguarding training completion rates**

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

The trust set a target of 90% for completion of safeguarding training.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>25</td>
<td>26</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>25</td>
<td>26</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>22</td>
<td>23</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>22</td>
<td>23</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall compliance rate was 96% (February 2018).

(Source: Additional data request)

Cleanliness, infection control and hygiene

The clinical areas we visited were visibly clean. There were low infection rates. Staff did not always comply with infection prevention and control policy. Audits showed variable compliance with hand hygiene principles.

We observed that staff cleaned their hands appropriately following the five moments for hand hygiene. This is defined by the World Health Organisation as the key moments when health-care workers should perform hand hygiene. We also observed compliance with ‘arms bare below the elbow’ policy to allow effective hand washing.

Staff wore personal protective equipment such as gloves and aprons when performing tasks where there was a risk of contamination. We also saw appropriate non-touch aseptic techniques used, for example when a nurse for the vascular access service inserted a peripherally inserted central catheters (PICC) line. A PICC line is a long, thin, hollow tube put into a vein often used for chemotherapy and other medicines.

We found adequate hand wash facilities and hand cleaning gels throughout the chemotherapy suite and waiting area.

However, audits of staff handwashing practices showed significant variation in compliance with worsening results (see below table). Following the March 2018 audit, the auditor discussed the results with the team on the chemotherapy unit and arranged to return to repeat the audit in two weeks.
<table>
<thead>
<tr>
<th>Date of Audit</th>
<th>Compliance with hand hygiene principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2017</td>
<td>95%</td>
</tr>
<tr>
<td>November 2017</td>
<td>84%</td>
</tr>
<tr>
<td>March 2018</td>
<td>32%</td>
</tr>
</tbody>
</table>

(Source: Additional data request DR167)

There were ‘I am clean’ stickers advising that items were cleaned and ready for use on many items of equipment.

The vascular access service monitored their performance related to infections. They reported low rates of site and blood stream infections related to vascular access they had inserted such as PICC lines (blood stream infection rate of 0.06 per 1000 catheter days).

(Source: DR177 Additional data request)

The Patient-Led Assessments of the Care Environment (PLACE) Programme results for the chemotherapy suite (2017) showed that the score for cleanliness of the environment was 97.9%. PLACE is a system for assessing the quality of the patient environment.

(Source: DR167 Additional data request)

The service undertook local audits to check the cleanliness of the environment and compliance with infection prevention and control policies. For example, we saw that in November 2017, an environment audit found minor areas for improvement, including dusty floor in a storeroom. These areas were highlighted following the audit. However, the overall compliance score for this audit was not completed.

(Source: DR167 Additional data request)

**Environment and equipment**

The environment was suitable for patients needs and equipment was available in order to provide safe care and treatment. However, despite systems to ensure that equipment was checked and serviced regularly, there were two items in the vascular service clinic (a bed and an ultrasound machine) that had not been appropriately maintained. Staff rectified this during the inspection.

There were systems to ensure that equipment was checked and serviced regularly. However, there were exceptions. We found that in the vascular service clinic room, based on the chemotherapy unit, two items of equipment had not been safety tested appropriately. These were a bed and an ultrasound machine. When we returned to the ward the following day, we found that the staff had reported the items and replaced the bed. The ultrasound scanner was due to be collected and replaced on the 23 February 2018.

There was equipment available for use in the event of a medical emergency. There was a resuscitation trolley available in the chemotherapy suite and the supportive care unit. The trolley was checked each day and a checklist was completed. There were tamper evident tags in place to
reduce the risk of unauthorised access. However, the tags were stored on the resuscitation trolley on the supportive care unit, which was not in line with the policy. We discussed this with the nurse in charge of the unit who stated they would rectify this.

The clinical areas had suitable flooring. We saw that some of the corridor flooring in the hospital was damaged and temporarily covered with tape to avoid trips. The quality of the estates varied throughout the Mount Vernon Cancer Centre. The chemotherapy suite was modern and purpose built. However, the supportive care unit had issues such as missing ceiling tiles in the clinical room and patients complained that the main room was too hot. We discussed the estates issues with the divisional directors. The maintenance of the estates was complicated, as they did not own the site; this was part of another NHS trust. The maintenance of buildings was continually being raised and issues chased accordingly.

The PLACE results for the chemotherapy suite (2017) showed that the score for the condition of the environment scored 100%.

We found there were processes in place for clinical waste management. Sharps bins were readily accessible with the majority of lids temporarily closed for safety.

Cytotoxic medicines are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). We saw that the service assessed the risks from handling cytotoxic drugs for employees and anyone else affected by this type of work, and took suitable precautions to protect them. A trust-wide policy for waste management was available which included dealing with cytotoxic waste and cytotoxic spillages. In addition, there was a department standard operating procedure for the checking, administration and safe disposal of Systemic Anti-Cancer Therapies (SACT). Cytotoxic waste was disposed of in the appropriate purple bins.

Assessing and responding to patient risk

There were gaps in the systems to minimise risk to patients. For example, there was no formal sepsis training for staff and an incident occurred when the trust’s identification policy was not followed.

Before patients started their course of chemotherapy treatment, staff would invite them to the Lynda Jackson Macmillan Centre to have a pre consultation presentation. Patients were given appropriate information (both verbal and written) about their chemotherapy treatment at a pre-consultation meeting. This included information on:

- The aim of treatment
- What the treatment is i.e. the name of the medicines
- The route the medicines will be given
- The frequency of administration
- The duration of treatment
- Potential side effects and action to take if these side effects occur.

A record of this consultation was made in the patient’s notes.
As part of this session, the patient would be given information verbally and an information pack. We saw that these included an alert card that patients could carry with them. It had a telephone number to contact a member of staff at any point if they had certain symptoms, such as a high temperature. This telephone line was manned by the acute oncology service, 24 hours a day seven days a week.

There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. The hospital had an acute oncology service (AOS) in line with the recommendations of the National Chemotherapy Advisory Group report (2009). This enabled a rapid response to be given when patients developed symptoms, for example, neutropenic sepsis. Neutropenic sepsis is a life threatening condition whereby the chemotherapy adversely affects the body’s ability to resist infection by affecting the bone marrow and decreasing white blood cell production. A key indicator of successful access to treatment is access to intravenous antibiotics within one hour for patients who were suspected of having neutropenic sepsis. Sepsis audits that were undertaken by the acute oncology service showed that they responded quickly. For example, the nurse told us they cannulated and administered antibiotics and fluids within 20 minutes.

Subsequent to our inspection, the trust provided raw data for the East of England neutropenic sepsis ‘door to needle’ audit from January to March 2018, which showed compliance was around 70% for treating within the hour.

The AOS was staffed by a supernumerary staff during the day and then a member of the ward staff would provide cover overnight. The nurse would use a form with standardised questions in order to triage patients appropriately. The UK Oncology Nursing Society (UKONS) toxicity risk assessment was used. The outcome of the call could include arranging an emergency admission if required.

However, no formal sepsis training had been provided to nursing staff to support early recognition and treatment. We were informed subsequent to our inspection that sessions were planned for April, May and June 2018.

(Source: DR166 additional data request)

We saw that patients were monitored appropriately before and during treatments. This included taking observations of vital signs, such as blood pressure, temperature and pulse. A standardised approach was used to identify whether a patient was deteriorating called the national early warning system (NEWS). If patients’ observations were outside of normal parameters, the NEWS was triggered. Staff were clear regarding getting assistance if a patient deteriorated. Depending on the situation, there was access to the on-call doctor and the resuscitation team on site.

Regular monitoring of patients receiving chemotherapy took place. This included checking blood results. Guidance was in place indicating; the required frequency of monitoring, which parameters should be checked and advice on appropriate adjustment of doses.

The identification policy provided by the trust states:

- The positive identification of the patient must be made on admission and before any intervention. Establishing correct identification can be achieved by:
  - Asking the patient to confirm their identity verbally.
  - This must be done by asking the patient to state their name and Date of Birth (DoB) and comparing this with the patient’s other documentation.
We saw that patients were provided with identification bracelets to wear while they received their treatment at each attendance. This reduced the risk of patients receiving the wrong medicine or treatment. However, there was an incident during the inspection related to the incorrect identification a patient prior to bloods being taken. This was under investigation and had not resulted in patient harm.

Documentation to support the assessment of patients, included checklists for the first day when attending treatment. This was to ensure that the patient received safe care and treatment.

Prior to patients receiving their chemotherapy treatment or in the event of a patient’s condition changing; the nursing staff completed a toxicity assessment. This was based on the UK Oncology Nursing Society (UKONS) Oncology/Haematology Treatment Toxicity Risk Assessment Tool. This evidence-based risk assessment tool grades the presenting symptoms and advises action accordingly using a red amber green (RAG) rating system. Sometimes this was done over the telephone or in a clinic setting. All the patients’ records we checked contained the toxicity assessment.

Other types of assessments such as risk of falls or malnutrition were not routinely completed by the service.

**Nurse staffing**

The lead nurse told us that the chemotherapy suite nursing staffing consisted of 27 whole time equivalents (WTE). There were two vacancies currently, a band 5 and 0.6 (WTE) Band 6.

Three staff provided temporary cover via NHSP agency. These staff were well known to the service and had competencies checked on commencement. They also took part in the annual in-house training courses to maintain competence. They provided approximately two-three shifts cover each week.

During the inspection, we saw that the actual staff numbers met planned numbers. Staff worked a variety of shifts to cover the opening times of 8am to 8pm. Some of the staff had merged with the unit following the closure of the Marie Curie Ward and their shifts had been honoured. There was an electronic roster system that was used to arrange staffing. This was set around 12 weeks in advance.

The divisional management team stated that they also had oversight of the staffing levels for the whole of the Mount Vernon Cancer Centre on a daily basis.

**Vacancy rates**

From December 2016 to October 2017, the trust reported a vacancy rate of 14% for nursing staff in chemotherapy at Mount Vernon Cancer Centre, which is worse than the trust target of 6%. However numbers of staff in chemotherapy are low which should be taken into consideration.

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

**Turnover rates**

From December 2016 to October 2017, the trust reported a turnover rate of 21.9% for nursing
staff in chemotherapy at Mount Vernon Cancer Centre, which is worse than the trust target of 12.7%. However, numbers of staff in chemotherapy are low which should be taken into consideration.

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

Sickness rates
From December 2016 to October 2017, the trust reported a sickness rate of 9.3% for nursing staff in chemotherapy at Mount Vernon Cancer Centre, which is worse than the trust target of 3.3%. However numbers of staff in chemotherapy are low which should be taken into consideration.

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

Medical staffing
Medical staffing for chemotherapy services was not always based on site. There was a trust wide service provided by 26 consultants. They would review patients in the outpatient clinics, prescribe chemotherapy, and monitor progress.

The chemotherapy suite was a nurse led service. Staff on the chemotherapy suite had access to contact details and rotas in order to access relevant medical staff for advice. In addition, there was always a senior on call doctor available, based on the inpatient wards. There was also a medical oncologist lead for the cancer division.

Records
Staff had access to records and information in order to provide safe care and treatment. Records were mostly paper based with patients' observations being captured electronically. We checked records associated with five patients during the inspection. We found that entries made in healthcare records were legible, signed and dated.

The patients' blood results were accessed electronically prior to chemotherapy treatment.

We saw that healthcare records were stored securely in a continually manned area to reduce unauthorised access and maintain confidentiality.

The service had not carried out an audit of the completion of healthcare records. Subsequent to our inspection, this had been added to the audit programme for the following year.

Medicines
The service had systems and processes in place in order to provide medicines including Systemic Anti-Cancer Therapy (SACT) safely. Medicines were stored, prescribed and administered appropriately.
SACT includes both biological therapy (therapies that use the body's immune system to fight cancer or to lessen the side effects that may be caused by some cancer treatments) and cytotoxic chemotherapy.

Cytotoxic chemotherapy medicines can kill cells or prevent their replication or growth. They target rapidly growing cells but not specifically cancer cells and so can have significant side effects when healthy cells are affected. Due to the high risks associated with chemotherapy, additional safety measures are needed to ensure both patients and staff are not put at risk.

All staff involved in the prescription, supply and administration of chemotherapy received competency based training prior to undertaking these duties. We saw evidence of this in the staff training records that we checked during our inspection.

The chemotherapy service trust wide used an electronic prescribing system, which was designed for chemotherapy treatment settings. This was in line with NHS England’s Commissioning for Quality and Innovation (CQUINs) payments framework.

Prior to administration, chemotherapy was stored in a designated area, separate from other medicines.

Refrigerators for storage of temperature sensitive medicines were locked and temperatures were monitored and recorded each day. Logs showed that this was checked consistently and that medicines had been stored at appropriate temperatures.

We saw that when administering intravenous chemotherapy, two chemotherapy trained nursing staff were involved in the checking process in line with the Nursing and Midwifery Council Standards. This included the patient confirming verbally their identification and wearing an identity bracelet.

There was a sub pharmacy department based on the chemotherapy suite. We spoke with pharmacy staff during the inspection, who explained that the training and rotation of staff in various departments supported them to feel part of the team. They described a patient first focused team. One of the pharmacists attended the clinic with medical staff to assess patient’s pre-treatment. They described this as having a positive effect on team working but also the impact on patient care. This was because they could advise and deal with some issues at this earlier point in the pathway.

Pharmacists supplied and counselled patients on oral chemotherapy treatments and other medications that the patient was taking home. We observed that that this was done appropriately and patients were informed about the storage and the regime to follow.

Nursing staff working on the chemotherapy suite had access to pharmacy and medical staff in order to safely administer medicines. We observed a nurse contacting a senior doctor by telephone to discuss a patient’s medicine prescription. The nurse explained that there was a rota and contact list for medical staff.

Chemotherapy treatments were produced on site through a contract with an external provider. There had been issues regarding supply of treatments on occasion. These issues were being monitored and reported as clinical incidents. We saw that issues related to the external provider were escalated to divisional level and plans put in place to work with them towards a resolution. Staff stated that the service provided by the supplier had improved currently.
We saw that registered nursing staff had to attend an annual update programme in order to continue administering chemotherapy treatment. This included annual updates for nursing staff on patient group direction (PGDs). These were available to enable authorised registered healthcare professional to give specific medicines in the case of reactions to treatment and for sodium chloride flush solution for vascular devices.

Intrathecal administration of chemotherapy was undertaken on Ward 10 at Mount Vernon Cancer Centre in a designated side room. Intrathecal chemotherapy refers to the process of injecting cytotoxic medicines into the cerebrospinal fluid to treat cancer. This is a potentially high-risk procedure and there is national guidance to support this practice. There was a designated member of medical staff that led on this, and there was a register of patients treated maintained. We saw that there was a trust policy to guide staff regarding intrathecal administration of chemotherapy, which was up to date. There were also systems and documents in place to support patient safety including, checklists for ordering, prescribing and administration. We spoke with two members of staff on Ward 10 and found that they were clear about their role in intrathecal administration.

**Incidents**

Staff we spoke with understood their responsibilities regarding reporting incidents. Incidents were reported and investigated. However, we were not assured that staff were always made aware of learning from incidents and there was a variable level of awareness regarding the regulatory duty of candour.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events within chemotherapy.  
*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in cancer services which could relate to chemotherapy and which met the reporting criteria set by NHS England from January 2017 to December 2017.

These were:

- Sub-optimal care of the deteriorating patient meeting SI criteria with one (50% of total incidents)
- Medication incident meeting SI criteria with one (50% of total incidents)

*(Source: Strategic Executive Information System (STEIS))*
We reviewed the investigation reports for each of the serious incidents. They did not directly relate to care provided by the chemotherapy suite.

Staff had reported 38 incidents from September 2017 to March 2018. Seven of the incidents were classed as minor, with 31 as resulting in no harm. We could see that the unit manager reviewed and responded to the incidents and that they were discussed at SACT meetings. These were quality review meetings that were attended by senior service leads. However, we did not see that incident were discussed at staff meetings. We also found limited evidence of learning following incidents when we inspected chemotherapy services in 2016.

Staff gave us examples of incidents that they had reported. These included extravasation, drug reactions and delays with receiving chemotherapy from the supplier.

We spoke with a member of the team that had reported a patient’s extravasation. Extravasation is the accidental leakage of certain medicines into the body from a drip in the vein. Some medicines can be dangerous when they escape from the drip or the vein. The symptoms can vary from blisters to severe tissue injury or even cause the cells or tissue to die. The member of staff had not received any feedback regarding this. Eight of the incidents reported (September 2017 to March 2018) related to extravasation. Subsequent to the inspection, we requested the extravasation policy for the trust. We were provided with a copy of a guideline for the nursing care and management of patients receiving SACT. This included monitoring, prevention and signs of extravasation. However, it did not inform staff regarding immediate actions to take when extravasation was suspected.

Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a trust policy relating to duty of candour, which outlined actions to be taken when something went wrong. However, we found that there was a variable level of awareness regarding the regulatory duty among nursing staff. Senior managers were aware of the duty of candour. They had ensured that a patient had been fully informed regarding a potential serious incident that had occurred, at the time of our inspection. We also saw that this apology and discussion was documented in the patient’s healthcare record.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment that was planned and delivered in line with evidence-based guidance such as from the National Institute for Health and Care Excellence (NICE).

The service contributed to the national lung cancer audit, which benchmarks performance and outcomes to evidence based best practice guidance.

The team at Mount Vernon Cancer Centre, also participated in self-declaration against national standards for chemotherapy services. We saw that this was completed and demonstrated compliance with the majority of the standards. One standard that was not met related to provision
of group pre-chemotherapy treatment consultations rather than individual sessions. However, this was monitored and evaluated closely.

(Source: additional data request DR405 self-declaration 2017).

The service provided care that was managed in accordance with NICE guidance.

The lead nurse for trust wide chemotherapy services told us that following their appointment, they had redesigned multiple guidelines and policies to consolidate them into four operating procedures. These were then implemented trust wide over the two sites. For example, there was a standard operating procedure that covered the nursing care and management of patients receiving Systemic Anti-Cancer Therapy (SACT), including scalp cooling for reducing patients’ hair losses. This was based on recent evidence base research and NICE guidance.

The majority of patient information resources that were used by the service were standardised and accessed through Macmillan cancer support charity.

The vascular service benchmarked their performance against previous year’s audits and published research. For example, they audited the intraluminal infection rate of the PICC lines they inserted. The infection rate was 0.06 per 1000 catheter days in 2016, an improvement compared to the previous year (0.1 per 1000 catheter days) reported at last audit.

(Source: DR177 Additional data request).

The service undertook local audits to ensure that they were providing effective care and treatment. For example, the acute oncology service had monitored response time to signs of sepsis. However, there were areas that had not been audited such as standards of healthcare records completion.

There were dedicated research areas incorporated into the supportive care unit and the chemotherapy suite. Patients that were included in research programmes would be cared for exclusively by the research nursing and medical team.

**Nutrition and hydration**

Patients were weighed when they arrived at the chemotherapy suite. This gave the staff an indication of whether they were gaining or losing weight. However, the weight was mainly used to ensure correct dosage of treatments were used.

Dietitians saw patients as required and this was included on the attendance checklists that were completed. We did not see the use of a malnutrition risk scoring tool or assessment in use. We discussed this with the lead nurse for chemotherapy services. They said that formal risk assessments were used on the inpatient areas.

We saw that patients received advice leaflets in their consultation packs about how to manage nausea and vomiting symptoms they may experience due to the chemotherapy treatment.

**Pain relief**

Pain assessment was not carried out routinely on the chemotherapy suite. However, pain experienced in the back, chest, abdomen, vascular access site were part of the toxicity risk
assessment tool used by staff on the unit. This was based on the UK Oncology Nursing Society (UKONS) Oncology/Haematology Treatment Toxicity Risk Assessment Tool. This evidence-based risk assessment tool grades the presenting symptoms and advises action accordingly using a red amber green (RAG) rating system.

Patient would bring any routine pain relief medicines with them to self-medicate while attending the chemotherapy suite.

Patient outcomes

The trust contributed to national audit programmes such as the Systemic Anti-Cancer Therapy (SACT) Dataset that covers patients receiving cancer chemotherapy in or funded by the NHS in England.

The trust also contributed to the National cancer waiting times database, and the Cancer outcomes and services dataset.

Lung Cancer Audit
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 54.0%, which was does not meet the audit minimum standard of 90%. The 2015 figure was 92.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 63.6%, this is not significantly different from the national level. The 2015 figure was 64.0%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.7%, this is not significantly different from the national level. The 2015 figure was 68.0%.

The one year relative survival rate for the trust in 2016 is 35.8% which is not significantly different from the national level.

(Source: National Lung Cancer Audit 2016)

Competent staff

Although the service made sure staff were competent for their roles and managers aimed to appraise staff’s work performance. The annual appraisal compliance rate for the chemotherapy suite was 74%. This did not meet the trust target of 90%.

When nursing staff joined the team, (without prior chemotherapy training), they would undertake theory training, usually through the local university. In addition, mentorship and practical competency assessment took place for up to six months.

We saw that registered nursing staff had to attend an annual update programme in order to continue administering chemotherapy treatment. Topics covered included;

- central venous access devices management,
• clinical research update,
• toxicity,
• patient experience,
• information about new treatments/regimes.

During the inspection, we checked staff files at random and found that competency documents had been completed. However, two out of three had not been countersigned by the unit manager. They stated this had been an oversight and would ensure they were signed.

### Appraisal rates at February 2018

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff receiving an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>14</td>
<td>20</td>
<td>70%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall appraisal rate for chemotherapy services staff was 74%. This did not meet the trust target of 90%.

*(Source: Additional data request)*

Staff told us that they were able to develop and had opportunities to attend courses and study days.

### Multidisciplinary working

**Staff across different disciplines worked well together to deliver effective care and treatment.**

Examples of multidisciplinary team (MDT) practice included:

- The pre-consultation presentations were provided by nursing staff from the chemotherapy suite and a volunteer for the Lynda Jackson Macmillan Centre to patients. Staff felt that this joint working with the volunteers worked well as there were staff on hand to comfort, take patients on tours of the site and provide one-to-one sessions as required.
- Each healthcare record that we checked during the inspection, contained written evidence of MDT involvement, such as dieticians, therapists and social workers.
• Pharmacists were attending outpatient consultations with medical staff that occur prior to patients attending the chemotherapy suite. They were able to offer pharmacy advice and support in a proactive way.

• At the point of starting chemotherapy treatment, the service would provide information about the treatment and any concerning signs and symptoms and action required, for the patient’s GP.

### Seven-day services

Chemotherapy services were provided as a day case and outpatient basis, Monday to Friday. The chemotherapy suite was open from 8am to 8pm. There were systems in place to support patients outside of these times via the acute oncology nurse contact triage service.

### Health promotion

The chemotherapy suite was adjacent to the Lynda Jackson Macmillan Centre. This provided a drop in resource to support people affected by cancer from diagnosis, through to moving on when treatment had finished. Examples of health and wellbeing support included:

- A significant library of information leaflets including diet and lifestyle advice.
- Skincare and make-up workshops for ladies, to boost confidence.
- Headwear workshops for those experiencing hair loss.
- Relaxation sessions and complementary therapies.

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

Patients were asked for consent prior to treatment and in accordance with the Mental Capacity Act 2005.

The trust had a consent policy to guide staff. We found from reviewing healthcare records that patients who were to undergo treatment had copies of documented consent forms. These were signed by the clinician and the patient.

The service provided pre-chemotherapy consultations for patients, which detailed how the chemotherapy would be given and what to expect. This included side effects and common symptoms. Staff told us that this was considered to be part of the informed consent process. We also observed informed consent being obtained from a patient prior to receiving a new PICC line.

The service had not carried out an audit of the consent process. After our inspection, this had been added to the audit programme for the following year.

Staff were aware of the mental capacity act and deprivation of liberty safeguards and understood that the least restrictive options were to be used. This was an improvement from our previous inspection, when we were not assured that staff had sufficient awareness.
The trust informed us that mental capacity act and deprivation of liberty were included as topics in safeguarding training. However, details of the training were not provided.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed many caring and compassionate interactions between staff and patients during our inspection.

For example, we observed a patient having a peripherally inserted central catheters (PICC) line replaced. A PICC line is a long, thin, hollow tube put into a vein often used for chemotherapy and other medicines. The nurse and the patient had an appropriate friendly rapport and were on first name terms. Screens were used as required to maintain the patient’s dignity.

The service collected patient’s feedback through surveys each month. **We found many positive comments** in these including that the ‘staff are excellent’ and ‘nothing is too much trouble’. They were ‘made to feel relaxed by staff’, who paid attention to detail’.

There were some negative feedback comments. However, these did not relate to the care given by staff and usually included issues such as delays and car parking.

**Emotional support**

Staff provided emotional support to patients to minimise their distress and took time to allay patients’ fears and support their emotional needs.

Patients we spoke with felt well looked after and safe. Some patients told us that they experienced delays such as waiting for medicines, which were frustrating. One patient felt that it would be good to have a named nurse for the duration of their treatment to make it feel a more personalised service.

The service had access to support groups, chaplains, counsellors, psychiatrists as required.

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

Staff involved patients and those close to them in decisions about their care and treatment.

The trust performed within the expected range (England average) for two questions relating to chemotherapy, in the 2016 National Cancer Patient Experience Survey.

We saw staff treated patients and their relatives with kindness, dignity and respect. Staff communicated patiently and compassionately with patients and carers.

Patients told us that they felt well informed regarding their care and treatment. This was also reflected in national cancer patient experience survey results for the trust.
The trust participated in the 2016 National Cancer Patient Experience Survey. The trust was within the expected range of the following two questions relating to chemotherapy:

- Q47: Beforehand patient had all information needed about chemotherapy treatment. (Case mix adjusted score for trust: 82%, England average 84%)
- Q48: Patient given understandable information about whether chemotherapy was working. (Case mix adjusted score for trust: 61%, England average 67%)

(Source: National Cancer Patient Experience Survey).

The service encouraged patients to attend with a member of their family or close friend for support. This was right from the outset, when being invited to the pre consultation presentation.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of patients.

The lead nurse for chemotherapy service stated that there had been an increase in attendance to the services and changes to treatment regimens recently. This was approximately an increase in footfall of 100 patients per month.

(Source: Additional information request DR189)

There had been changes in the provision of services to meet the increasing demand. This included the merger of the staff from the Marie Curie Ward with the chemotherapy suite team. Then a supportive care unit was opened in the vacant Marie Curie ward. This was developed to reduce the number of patients attending nearby emergency departments, by providing day ambulatory care interventions such as, drainage of fluid, blood transfusions and line removals. However, it also could reduce some of the numbers of patients attending the chemotherapy suite, by providing simple short Systemic Anti-Cancer Therapy (SACT) treatments at the supportive care unit instead.

There was a vascular access service based at Mount Vernon Cancer Centre. This provided a service four days a week (not at the weekend) to insert and assist with vascular access such as peripherally inserted central catheters (PICC) line. A PICC line is a long, thin, hollow tube put into a vein. It is used to give chemotherapy and other medicines. This service had increased since our previous inspection. However, this was still being developed further with a job advert out at the time of our inspection for a Band 7 full time nurse to also work for the service. Staff said that there was approximately a three week wait currently for the vascular service and this would improve with more cover. As the service has developed, they were also providing more educational input, for example study days four times a year and supported competency completion.

The Lynda Jackson Macmillan Centre at Mount Vernon Cancer Centre site provided a free of charge services to patients under the care of consultant oncologists. These included information, support groups, workshops, and homeopathy and therapy sessions.
Meeting people’s individual needs

The service was responsive to meet patients’ individual needs. However, we were not assured that patients were always provided with translation services when they were required.

The lead nurse for chemotherapy services said that they had access to various teams or specialists to assist them to meet individual’s needs. These included; leads for safeguarding, dementia, learning disabilities and social workers. The Patient-Led Assessments of the Care Environment (PLACE) Programme (2017) recognised that the chemotherapy unit provided suitable facilities and environment for patients with a disability (scored 97.7%), and scored 73% for suitability for patients who were living with dementia.

Staff gave us an example of when they had arranged for a patient to receive their chemotherapy treatment in a side room on the inpatient unit rather than on the chemotherapy unit, due to the individual’s needs.

Patients were provided with hot and cold drinks throughout the day and a sandwich lunch. Staff told us that individuals dietary requirements could be met with alternatives being easily available.

There were two bed spaces that had privacy curtains and mobile screens were available if required. There were quiet rooms available for private discussions to be held. In the main treatment area patients and staff were quite close together and conversation could be overheard. Care was taken by staff to promote confidentiality. The PLACE audit results (2017) reflected this challenge with the score for privacy of 77.7%

There was a trust policy to guide staff regarding access to translation/interpretation services. Staff we spoke with were aware of how to access these services. However, this seemed to mainly be reliant on members of staff providing the translation and being on a contact list. The policy was clear that face to face interpreting was to be used in exceptional circumstances. During the inspection, there was an incident that seemed to be related to lack of access to translators. The incident was being investigated, which included access to these services.

Many information leaflets were available throughout the surgical wards to guide patients and relatives. These were all in English and no ‘easy read’ versions were seen.

Access and flow

Access for first treatment in 62 days of urgent national screening referral was lower (worse than) than the England average.

However, patients could access treatment when they needed it for some aspects of their care. Times from referral to first treatment in line with the England average for the first treatment in 31 days of decision to treat and the first treatment in 62 days of urgent referral. Patients seen within 14 days of referral was better than the England average.

Patients were experiencing delays when attending the chemotherapy suite service.

The chemotherapy suite was open Monday to Friday, treating an average of 40 patients per day.
Cancer waiting times
From October to December 2017, the trust performed better than similar trusts in one indicator and the same as similar trusts in three indicators.

Indicator the trust performed better than other trusts:
- Cancer – seen by specialist in 14 days of urgent GP/dentist referral (%) (Trust: 97.4%, England average: 94.9%)

Indicators the trust performed similarly to other trusts for two targets:
- Cancer – first treatment in 31 days of decision to treat (%) (Trust: 94.9%, England average: 97.7%)
- Cancer – first treatment in 62 days of urgent GP/dentist referral (%) (Trust: 77.7%, England average: 83.1%)
- Cancer – first treatment in 62 days of urgent national screening referral (%) (Trust: 74.6%, England average: 90.8%)

(Source: NHS England)

However, locally we found evidence of delays in accessing treatment. This was also noted from our previous inspection.

We noted that during the inspection, there was a display board in the patient’s waiting room that stated that 62.5% patients did not experience delays at the chemotherapy suite that month (February 2018). The unit lead was aiming for this performance to be at 75%. However, we found that this figure was calculated from the subjective source of patients’ feedback forms that were completed. Therefore, we were not assured that the actual amount of delay experienced by patients attending the suite was being monitored accurately.

The theme of delays came from multiple sources including, staff and patients accounts and patients feedback survey forms. Examples given included:

- Some patients go to clinic before they have their treatment. If the clinic appointment runs late this impacts the timeliness of the treatment at the suite.
- Sometimes patients have to wait due to healthcare records not being available.
- Patients experience delays getting to the suite on time due to difficulty finding a car parking space.
- Staff told us they often worked late to complete patient’s treatment.
- Staff told us that sometime patients had to be transferred to the inpatient ward to complete their chemotherapy treatment.

We requested how often patients would need to transfer to the inpatient ward in order to complete their treatment. However, there were no records kept of this.

The lead nurse explained that they wanted to reduce delays experienced by patients.
Learning from complaints and concerns

There were very few complaints. Staff were aware of general themes, which included waiting times.

Summary of complaints

From November 2016 to November 2017, there were three complaints about chemotherapy. The trust took an average of 36.0 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be closed in 30 days of receipt of the complaint. Two complaints were regarding waiting time and one was about environment.

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

Further details were provided showed that there had been five complaints in the six months ending March 2018. Three of the complaints were not upheld, one partially upheld and one remained open.

We saw that there were leaflets signposting patients and relatives regarding the complaint process, available throughout the service.

Staff were aware of general categories of complaints that had been made, such as delays in treatment. However, there was not a clear plan in place to reduce delays.

Is the service well-led?

Leadership

The service leaders were experienced, available and accessible to staff.

There was a lead nurse for chemotherapy services across the trust. They were supported by unit managers, consultants and a senior management team for Mount Vernon Cancer Centre. The lead nurse covered services based on two different hospital sites for the trust, located approximately 50 minutes drive apart. This provided logistic challenges. However, the lead chemotherapy nurse explained that they had an open door policy and tried very much to ensure that they were available for staff. They had one-to-one sessions for example, with all new members to the team. There were unit manager based on each chemotherapy suite.

Chemotherapy services were under the management of the trusts cancer care division. There was now a head of nursing, chair and director of operations for the cancer care division. The management team were new as there had been a restructure and change of personnel. Some of the changes were in response to the unique challenges and opportunities that the Mount Vernon Cancer Centre provided.

The supportive care unit did not fall under the remit of the lead nurse for chemotherapy services. This area was developed from the inpatient ward team and was managed by the newly appointed head of nursing for Mount Vernon Cancer Centre currently, until a matron vacancy was filled.

Aspiring managers at the trust were able to access a three day leadership training course.
Vision and strategy

There was a new strategy for Mount Vernon Cancer Centre. However, as this was new, staff were not all clear about the vision and strategy.

The Mount Vernon Cancer Centre management team informed us there was a strategy for the site. This included a vision and a set of values, with quality and safety the top priority. The management team explained that the strategy had been developed with the full involvement of the staff at MVCC. Staff we spoke with during the inspection were not clear about the strategy for the service. However, this was new and had been presented to the board on 7 March 2018.

The lead for chemotherapy had an improvement plan for the service. This contained actions that had been identified and progress with these. It was not aligned with a strategy for the services or the new strategy.

Culture

Staff working on the chemotherapy suite described the unit as being ‘very busy’ but the teamwork was good. They felt generally well supported to do their roles.

There had been a recent merger of two teams. The Marie Curie ward staff had merged with the existing chemotherapy team. We saw minutes of meetings to discuss this with Band 6 team members from both teams. This was in order to merge teams with the least upheaval as possible. There had not been any staff leaving due to this process.

There was an overall culture of teamwork that was noted. This included members of the wider multidisciplinary team. Staff were proud to provide the care to patients and felt they did a good job. However, staff felt that they would benefit from more opportunities to communicate with each other and share ideas at meetings.

Governance

There was a system to provide governance of the chemotherapy service. The arrangements were undergoing some development at a divisional level.

We saw that there was a system and roles to provide governance of the service, including heads of department, divisional and Systemic Anti-Cancer Therapy (SACT) meetings.

The ‘clinical governance oversight and heads of department’ meetings were held monthly. This was for the managers and clinicians including consultants at Mount Vernon Cancer Centre. From the minutes, we were unable to gauge attendance levels, as these were kept separately. The agenda was business and financial focussed. For example, there was no discussion about incidents, complaints, audits or reviews of risk registers.

There was also Systemic Anti-Cancer Therapy (SACT) meeting held each month to discuss quality issues. We were told that this was attended by the lead clinician, clinical director, administrative staff, and leads for areas such as PALS and outpatients departments.
The governance arrangements for the service were undergoing some development. The lead nurse was providing a report to divisional meetings regarding the chemotherapy service. Divisional level meeting minutes were requested but not provided.

**Management of risk, issues and performance**

There were systems in place for identifying risks, although this did not appear to be effective or reviewed during meetings. The service was often reactive when things went wrong.

At monthly SACT meetings we saw an example when issues had been responded to by Systemic Anti-Cancer Therapy (SACT) meeting. There had been issues with delays in receiving chemotherapy treatments made by external suppliers on site. We saw from the minutes that concerns had been raised with the external supplier resulting in the director (of the supplier) attending the meetings. Key performance indicators had then been developed jointly to monitor the ongoing performance.

We saw that incidents were discussed at the SACT meetings. It was recognised that extravasation had been noted as a theme from incident reporting. However, discussion about learning or focus on prevention of these incidents was not evident.

There was a risk register for the cancer services division. This contained some risks that were particularly relating to chemotherapy services at Mount Vernon Cancer Centre.

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Current risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>6027</td>
<td>Audits within the chemotherapy units (environmental)</td>
<td>9</td>
</tr>
<tr>
<td>5554</td>
<td>Call bell system not fit for purpose</td>
<td>9</td>
</tr>
<tr>
<td>5556</td>
<td>Long standing issue with pneumatic system (for transporting blood samples)</td>
<td>10</td>
</tr>
<tr>
<td>6026</td>
<td>PGD training for neutropenic sepsis</td>
<td>9</td>
</tr>
<tr>
<td>5819</td>
<td>Risk of insufficient staffing in both chemotherapy units</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: DR138 Additional data request)

We could see there was evidence of reviews of the risks; each had an identified person responsible for the risk and mitigations were included. However, it was noted that some of the risks had not been resolved despite costings and identified solutions being found. For example, a solution had been found for the call bell issue. The issue was low volume of the alarm with a potential risk of delay in response. This had not been resolved and it had been entered onto the register in 2016.

The lead explained that due to close proximity to London, attracting a suitable workforce was difficult, thus increasing the risk of employing the right staff. When staff achieved their chemotherapy competencies they remained at a Band 5. This had been identified as a risk to retention. This was listed on the service improvement plan provided by the lead nurse.

After the inspection, we requested an update regarding the PGD training for neutropenic sepsis. The risk had described delays in providing the training due to workload and capacity. However, the
day following our request for an update, all the Band 6 nurses in the chemotherapy unit received training. In addition, progress with implementing an action plan following the neutropenic sepsis audit report, including PGD training was to be presented at the mortality review group in May 2018.

Information management

The service collected information and used secure electronic systems. However, it did not always analyse information support activities and continually improve.

There were multiple sources of information that indicated that patients were experiencing delays accessing treatment often following arrival at the chemotherapy suite (see access and flow section). It was acknowledged by local leaders that the access pathways were complex. However, data was not being used to fully understand the issues. This meant therefore that they were unable to know what to change in order to improve the responsiveness of the service.

The pre-consultation presentations had set slides that were used across the trust to ensure standardisation of the level of information that was provided to patients about the chemotherapy treatments.

Engagement

The service engaged well with patients, to improve services.

Patient engagement

The service actively engaged with patients in order to develop the services that were provided accordingly. For example, there were focus groups held that revealed that patients wanted to provide advice about symptom management, such as from their own experiences, for other patients. Therefore, we saw that some of the information leaflets had been developed to incorporate professional clinical advice alongside appropriate top tips from patients.

There had been a patient representative, who attended monthly quality meetings for the service until recently. However, they were currently unavailable.

The Lynda Jackson Unit supported the chemotherapy unit with some patient engagement. Particularly with the evaluation of how patients find the group pre-treatment consultations.

Staff engagement

Staff did not always feel actively engaged or empowered.

Staff we spoke with on the chemotherapy suite during the inspection generally felt they would benefit from more formal meetings to receive updates and information. Communication channels were informal and did not encourage staff to share ideas. Staff told us there was no handover to catch up or share information when they came on duty.
Managers explained that there had not been many meetings for staff recently. They had struggled with poor attendance. However, there had been a meeting held in December 2017. 11 staff had attended and areas were covered included housekeeping, key messages and thanking the staff for their hard work. There was no reference or discussion related to sharing learning about incidents or complaints.

**Learning, continuous improvement and innovation**

The pre-consultation process had been through continuous evaluation. It had been provided as a group rather than as a one-to-one approach and patient’s experience was carefully monitored. We saw that at least each year there had been enquiry into how the pre consultations were being received. This had led to continual refinement.

We noted that the administration staff had been grouped to work together on the chemotherapy suite called a ‘booking hub’. This was a pilot to improve the booking process and ensure that there were more staff around that could cross cover administration roles.

The divisional management team stated that there would be a chemotherapy redesign programme in the future, to continue to meet demand and improve. However, the lead nurse for the service did not make reference to this.
Facts and data about this service

The urgent care centre (UCC) at the Queen Elizabeth II (QE2) hospital is open 24 hours a day, seven days a week. It is a nurse-led service co-located with a GP service and provides treatment for adults and children over one year of age with minor injuries and illnesses.

All patients are assessed by a registered nurse. Those with minor injuries are treated by emergency nurse practitioners (ENP) and those with minor illnesses by a GP from the co-located GP service. We did not inspect the GP service as they were from an external provider commissioned by the local clinical commissioning group and would form part of a separate inspection. Patients with more serious injuries or illnesses are directed or transferred to the emergency department at the Lister Hospital in Stevenage.

For the year ending March 2017, 44,000 patients had attended the urgent care centre. Of these, approximately 30% were children up to the age of 16 years.

We last inspected this service in October 2015 and rated it as requires improvement.

We carried out an announced inspection of the UCC on 20 and 21 March 2018. During our inspection, we spoke with 12 members of staff and two patients and their families. We looked at 12 sets of patients’ records.

Details of emergency departments and other Urgent and Emergency Care services

- The New QEII
- Lister Hospital (Emergency Dept (ED))

(Source: Trust Routine Provider Information Request)
Activity and patient throughput

Total number of urgent and emergency care attendances at East and North Hertfordshire NHS Trust compared to all acute trusts in England.

There were 159,019 attendances from April 2016 to March 2017 at East and North Hertfordshire NHS Trust as indicated in the chart above. The urgent care centre (UCC) QE11 hospital saw approximately 44,000 patients in the same time period. 30% of them were children of 16 years or younger.

(Source: NHS England)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and but did not make sure everyone completed it.

Although mandatory training had improved since our last inspection, not enough nurses had been trained in immediate life support for adults or children.

Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training courses</th>
<th>Nursing staff trained (YTD)</th>
<th>Eligible nursing staff (YTD)</th>
<th>Completion (YTD)</th>
<th>Trust target</th>
<th>Was the target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene)</td>
<td>151</td>
<td>160</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>151</td>
<td>160</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>149</td>
<td>160</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>148</td>
<td>160</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>142</td>
<td>159</td>
<td>89.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>140</td>
<td>160</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>137</td>
<td>160</td>
<td>85.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>125</td>
<td>160</td>
<td>78.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff in the UCC was 89.4%. Of the eight mandatory training courses delivered by the trust to nursing and midwifery, four met the completion rate target of 90%.

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

Although all nurses had completed basic life support training only 73% had been trained in immediate or advanced adult life support. The trust could not tell us how many nurses had been
trained in paediatric immediate life support. They did acknowledge senior staff required more training and were planning to do this in the next few months. Therefore, it was possible that, at some times, there would be no nursing staff capable of resuscitating adults and/or children.

**Safeguarding**

_Not all staff had the right level of safeguarding training. Although staff had some understanding of how to protect patients from abuse, there were no easily available prompts to help nurses decide whether a child was at risk of abuse._

Staff did not always understand how to protect patients from abuse as 35% had not received sufficient training in safeguarding children. It was not always possible to work with other agencies as staff did not have access to the local child safeguarding register

**Safeguarding training completion rates**

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

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

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and nursing staff in East and North Hertfordshire NHS Trust is shown below:

**Safeguarding Training Completion by module – Nursing and Midwifery Staff**

| Training Courses                          | Number of nursing staff trained (YTD) | Number of eligible nursing
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safeguarding Children Level 1 - 2 Years</strong></td>
<td>157</td>
<td>160</td>
</tr>
<tr>
<td><strong>Safeguarding Children Level 2 - 2 Years</strong></td>
<td>155</td>
<td>159</td>
</tr>
<tr>
<td><strong>Safeguarding Adults Level 1 - 2 Years</strong></td>
<td>149</td>
<td>160</td>
</tr>
<tr>
<td><strong>Safeguarding Adults Level 2 - 2 Years</strong></td>
<td>148</td>
<td>159</td>
</tr>
<tr>
<td><strong>Safeguarding Children Level 3 - 1 Year</strong></td>
<td>113</td>
<td>145</td>
</tr>
</tbody>
</table>

The trust’s overall nursing safeguarding training completion rate was 92.2%. The trust met the completion rate target for four out of the five safeguarding modules it delivered.

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

The trust had a safeguarding lead and team. Their details were on display in staff areas and staff knew who to contact if they had any safeguarding queries.
Of all the qualified staff in the UCC, 85% had completed level 2 adult safeguarding training. This was slightly less than the trust standard.

Not all staff had the right level of safeguarding training in the urgent care centre. The Royal College of Paediatrics and Child Health (Intercollegiate document-March 2014) states that nurses working in urgent care settings should have undergone level three children’s safeguarding training. Only 65% of nurses working in the UCC had received this training. Therefore, there was a risk that some staff did not have sufficient knowledge to identify and assess children at risk of abuse. However, this was better than training rates at our last inspection when no staff had received level three training.

Reception staff checked an on-line database for all children, who presented in the department who were under 18 years old to ascertain if there had been a previous notification of potential or actual child abuse. The database was a new national system which is intended to include the child protection registers from all areas of England. Registers from some parts of the country had not yet been included. Reception and nursing staff told us that the separate GP computer system sometimes identified children at risk of abuse who had not been identified by the database at reception.

A paediatric liaison nurse attended the unit weekly to review both the records of all children aged five years or under and any safeguarding referrals. Staff were aware that families where a parent abused drugs or alcohol, or where there was a history of domestic violence, it was more likely that there may be issues surrounding child protection. We saw that UCC staff completed referral forms for vulnerable families which were sent to the local safeguarding team.

**Cleanliness, infection control and hygiene**

The service had effective prevention and control processes in place. This was an improvement since our last inspection.

At our last inspection in October 2016, we found that cleaning rarely took place after 4pm. In the evenings there were sometimes overflowing used linen bags in the dirty utility room. This increased the risk of environmental contamination. However, there had been improvements in hygiene since our last inspection and infection risks were well controlled. The UCC was visibly clean and we saw support staff cleaning the department on a regular basis. We observed that staff used antibacterial hand gel regularly and washed their hands before and after patient contact.

There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. Results from the last infection control audit (including hand hygiene) showed 95% compliance with infection control policies. However, this audit had taken place in May 2017 and staff did not know if they had been repeated more recently. There had been an environmental audit in March 2018 showing that public areas were clean and that waste bins were properly assembled, clean and emptied regularly.
'Bare below the elbow' policies were adhered to and staff wore minimal jewellery. In addition, personal protective equipment, for example, gloves and disposable aprons were used. This was all in accordance with the trust’s infection control policy.

**Environment and equipment**

Whilst overall the service had suitable premises and equipment, some aspects were not well maintained. In addition, there was no separate waiting area for children and no separation between them and adult patients.

There was adequate space and seating in the waiting area of the UCC and during our inspection we saw no patients standing whilst waiting to be seen. The waiting and reception area was close to several external doors and was very cold during our inspection. Staff told us that this often happened in the winter as the hot air curtain between the two sets of automatic doors did not work. Staff reported that some parts of the underfloor heating also did not work. The clinical site manager told us that the problem had been reported to the maintenance department but they had been unable to resolve the situation. After complaints from patients, the site manager had arranged for the doors nearest to the waiting area to be closed and for people to be diverted to other entrances. This had improved the temperature of the waiting and reception area. Reception staff were provided with portable heaters.

There were no toys or entertainment provided for children in the waiting area. There was no separate waiting area for children and no separation between them and adult patients. This meant children were not protected from the risks associated with being in a public environment with adults.

The unit was well equipped and equipment was checked daily to ensure that it was ready for use. We saw maintenance records showing a regular programme of maintenance and servicing was planned for and had taken place.

There was appropriate resuscitation equipment for both children and adults. This was stored in tamper-evident “grab bags” which were checked weekly in line with trust policy.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Used bins were sealed securely and were not overfilled. This had improved since our last inspection.

**Assessing and responding to patient risk**

Triage assessments were inconsistent and were sometimes delayed. Early warning scores were not used to identify patients whose condition was at risk of deteriorating. Staff had not been trained to assess sick children or to recognise sepsis in adults or children. There was no written guidance for staff to follow if a child collapsed in the UCC. Staff did not always follow the guidance provided for the management of very sick adults.

We raised these issues with the trust at the time of our inspection and have received a written response regarding the improvements they intend to make.

Systems within the department did not always minimise the risk to patients when they first arrived.
in the department. The Royal College of Emergency Medicine (RCEM) states that an initial clinical assessment of patients should take place within 15 minutes of arrival (RCEM Initial assessment of emergency department patients - 2017). This assessment is often known as triage. The arrangements for triage assessments had changed since our last inspection. During this inspection, and in the week before, there sometimes had been delays of up to 40 minutes before a nurse assessed patients. This meant that the condition of patients with urgent problems could have deteriorated while they waited. Trust data showed that 17% of patients had not been assessed within 15 minutes (September 2017 – February 2018).

Nurses told us that receptionists would tell them if a patient was giving cause for concern and needed to be seen urgently. However, receptionists had been given no training in the recognition of “red flag” symptoms such as chest pain or shortness of breath. They told us that they relied on experience and common sense. In addition, receptionists sat behind a high desk and were unable to see all the patients in the waiting room. Therefore, it was not possible for them to always see whether a patient was deteriorating and needed to be seen urgently.

Nurses used the Manchester triage system to assess patients. This helped nurses to assess the degree of urgency associated with the illness or injury that the patients had presented with. Once the patient has been assessed they were given a priority category between one and four. Category one patients need to be seen immediately and category four patients should be seen within two hours.

However, staff during our inspection did not seem to be familiar with the detail of the triage system. For example, the system determined urgency by the whether the patient’s temperature is “hot” or “very hot”. We asked three nurses how high a patient’s temperature needed to be, in centigrade, before they were regarded as very hot. None of them were able to give an answer. In addition, the initial assessment of children did not follow the centre’s own guidelines. These stated that no child should be given a priority category lower than three. During our inspection at least two young children were given a priority category of four. We looked at the records of four children who had been seen in the previous week and found that three of them had been regarded as category four. An adult with head injuries with loss of consciousness and another with an obvious broken arm had also been assessed as able to wait for two hours before being treated. This confusion meant that the risk to patients’ health had not been properly assessed.

Records showed that 95% of patients with minor injuries were treated within two hours of arrival.

The UCC was designed to see patients of one year and older, but there was no paediatric team at the hospital. However, staff could contact children’s doctors and nurses at the emergency department at the Lister hospital if they needed specialist advice. Staff told us that if a child under the age of one year presented with an injury at the UCC they were assessed by an emergency nurse practitioner (ENP) and then directed to a GP or transferred to the emergency department at the Lister hospital, if necessary.

There was no lead nurse for children in the UCC although staff could contact specialist nurses at The Lister emergency department for advice. There were no qualified children’s nurses working in the UCC even though 30% of the patients were children of 16 years and under. None of the
staff had received recent training in the assessment and treatment of children and there was no
evidence that they had received training in immediate life support for children. We asked to see
guidance for staff to follow if a child collapsed in the urgent care centre but were told that there
was no official guidance. Staff told us that they would ask one of the GPs to help. However, they
did not know whether the GPs had been trained in the treatment of critically ill children.

Staff did not use an early warning scoring system to quickly identify patients whose clinical
condition was at risk of deteriorating. This meant that it was harder to identify those patients
whose illness was more serious than initially identified. In addition, the lack of an early warning
score meant that the need for sepsis screening was not always identified. Two nurses that we
spoke with were unable to identify the triggers for sepsis screening and there were no prompts
easily available in assessment and treatment areas. None of the nurses had been trained to
recognise sepsis in children. 53% of nurses had been trained to recognise sepsis in adults.

There were clinical pathways for potentially serious conditions such as chest pain and head
injuries. During our inspection we observed that staff did not follow these pathways. For example,
the pathway for patients with chest pain stated that observations of heart rate and blood pressure
should be recorded and an ECG recording taken. If these were abnormal an ambulance was
called to take the patient to the emergency department. Instead, a GP was asked to see the
patient, to direct treatment and to decide whether the patient should be transferred to the
emergency department.

Other guidance stated that ENPs (emergency nurse practitioners) saw all children over one year
with minor injuries. Triage nurses told us that some ENPs did not see children with certain types
of injuries, for example, head or facial injuries. We observed two children over one year of age
with minor injuries waiting to see a GP.

When patients with mental health problems attended the centre staff could ask for telephone
advice from the psychiatric liaison team at the Lister Hospital. This was available from 9am to
9pm seven days a week. However, there was no risk assessment to determine whether patients
with mental health problems were high, low or medium risk. The lack of an assessment had been
recognised by one of the ENPs who was working to remedy the problem. However, it was not
clear when a risk assessment would be in place.

Nurse staffing

The trust has reported their staffing numbers below for year of 2016/17 and year to date which
covers April to October 2017.

<table>
<thead>
<tr>
<th>Core service</th>
<th>2016/17</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
</tr>
<tr>
<td></td>
<td>staff</td>
<td>staff</td>
</tr>
<tr>
<td>Urgent and Emergency Services</td>
<td>117</td>
<td>186</td>
</tr>
</tbody>
</table>
The fill rate for nursing staff increased from 62.9% in 2016/17 to 90.4% for 2017/18 year to date.  
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

Nursing staff and emergency medical technicians rotated between the emergency department (ED) at the Lister Hospital and the UCC. There was a minimum of one emergency nurse practitioner (ENP) and one staff nurse at all times. ENPs are experienced and specially trained nurses who are qualified to diagnose and treat injuries and conditions within the scope of practice of an urgent care centre. Additional nursing staff and emergency medical technicians worked between 10am and 8pm when more patients attended the centre.

Vacancy rates  
From December 2016 to October 2017, the trust reported a vacancy rate of 22.7% in urgent and emergency care for the nursing staff. (This includes vacancies at the emergency department at the Lister Hospital) This was above the trust’s target of 6%.  
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

We looked at the UCC rota for the eight weeks before our inspection and found that there was only one shift that had not been filled.

Turnover rates  
From December 2016 to October 2017, the trust reported a turnover rate of 10.5% in Urgent and Emergency Care this was within the trust target of 12.7%. (This includes staff at the emergency department at the Lister Hospital)

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

Sickness rates  
From December 2016 to October 2017, the trust reported a sickness rate of 3.2% in urgent and emergency care which is around the same as the trust target of 3.3%.  
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage  
No agency staff had been used in the UCC in the eight weeks prior to our inspection.

Medical staffing  
The GPs who worked in the UCC were available from 8am to midnight. They were employed by an external provider who had been commissioned by the local clinical commissioning group and were not inspected.
Records

Patient records were fragmented and difficult to follow. A combination of computer and paper records was used. Patients’ registration details were recorded on the unit’s computer system, which then produced a one sheet paper record for staff to use. If a patient was already on the computer system the receptionist checked that all details were up-to-date.

The paper sheet was placed in a box at the back of reception so that the triage nurse knew which patients were waiting. The records were supervised at all times. The triage nurse used the paper sheet to record observations such as blood pressure and temperature as these could not be entered onto the computer system, although all other triage information could be recorded. If the triage nurse needed to administer pain relief another paper document was used to record the details of the medicine administered. By using three different recording methods there was a risk that important information could be missed. We were told that, once the patient had left the centre, the paper records were sent to a secure off-site storage facility. None of the staff could tell us how long the records were stored for.

Information recorded by nurse practitioners on the computer system was clear and comprehensive. However, because of technical difficulties, they used the free text fields on the computer rather than the drop-down menus. This made it difficult to retrieve key information such as diagnosis or treatment.

The GPs who worked in the department used a different computer system. Patients with a minor illness had to be re-registered before they could see a GP. Nurses could not use this system and so observations (such as blood pressure, heart rate and temperature) were not entered.

Medicines

There had been improvements in the storage of medicines; however, medicines were not always administered according to best practice.

Best practice was not always followed when prescribing and giving medicines. Although some of the Emergency Nurse Practitioners (ENPs) had qualified as non-medical prescribers many of the nursing staff administered selected medicines under guidance, known as patient group directions (PGDs). The PGDs in the unit had expired in August 2017 and had not been replaced. In addition, there were no PGDs for local anaesthetics needed before suturing wounds. We brought this to the attention of senior staff and were told that revised PGDs were in place at the emergency department at the Lister Hospital. They intended to send copies to the UCC by the end of our inspection. However, we did not see them.

Medicines were stored in line with the trust’s medicines management policy and fridge and room temperatures were regularly checked and temperatures recorded. The recording charts showed the fridge and room temperatures were within an acceptable range. Storage of medicines had improved since our last inspection.

We checked the storage of controlled drugs, which include strong pain relief medicines and sedatives. These were stored correctly, carefully monitored and we found that the stock balance was correct.
A wide-ranging stock of medicines was kept in the department for patients to take home if necessary. These included antibiotics and pain relief tablets. Nurses told us that it was very unusual for a patient to need medicine that was not held in stock. However, one of the GPs would be asked to prescribe such a medicine if necessary. There was always specialist pharmacy advice available from the on-call pharmacy service at the Lister hospital.

**Incidents**

**Staff recognised incidents and reported them appropriately.**

Staff were aware of their responsibility to report incidents both internally and externally and used the hospital’s electronic reporting system. There had been an average of five incidents per month in the last year. The majority were associated with health and safety, estates issues and staffing. Nurses told us that feedback was provided if they requested it or if the incident was serious or recurring. Staff could not describe any learning from incidents and they were not discussed at staff meetings.

Reporting and feedback had improved since our last inspection.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events in the UCC.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in the UCC at QE11 hospital.

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

**Is the service effective?**

**Evidence-based care and treatment**

The service did not always provide care and treatment based on national guidance or demonstrate evidence of its effectiveness.
The clinical guidelines available to staff did not contain any references to national guidance produced by organisations such as National Institute for Health and Care Excellence (NICE), the Royal College of Emergency Medicine (RCEM) or the Royal College of Nursing (RCN). Most of the guidelines were out of date, having been written in 2003. The guidance for application of plaster of Paris was dated 1998. When we pointed this out to a senior member of staff they told us that current guidelines were available on the hospital intranet. However, when we gained access to the intranet none of the guidance was relevant to the UCC or to the emergency department.

There were occasional audits of patient records to assess whether local practice had been followed for patients with minor injuries. However, none had taken place since May 2017. The two audits we were shown were methodical and produced a score out of one hundred. They scored 76 and 77 respectively. We looked at 10 patient records which showed that clinical assessment was methodical, appropriate and clearly documented in the majority of cases.

The UCC met 12 of the 19 principles set out by the RCEM document; ‘Unscheduled care facilities’ - 2009. Those that were not present were; training needs analysis for staff, paediatric immediate life support training, patient group directions, the ability to demonstrate competence in the assessment of vulnerable groups of patients, a clinical lead for the service, adherence to national clinical guidance and regular clinical audit.

All x-rays were reviewed by a radiologist (specialist imaging doctor) within five days. This ensured that, if there were any discrepancies in diagnosis, the patient would be recalled and re-assessed in a timely manner.

Records showed that, where appropriate, patients were referred back to their own GP once their urgent care needs had been met.

There was a wide range of information leaflets available to help patients manage their injury or illness. We reviewed a random sample of these and found that they followed current national guidance.

**Nutrition and hydration**

Data showed that 95% of patients spent less than two hours in the UCC, therefore meals were not provided. Drinks and snacks were available from a vending machine in the waiting room and a nearby café. Patients told us that they were happy with these facilities.

Staff spoke confidently about recognition of signs of malnutrition and dehydration.

**Pain relief**

Staff did not assess or monitor patients regularly to see if they were in pain. This had deteriorated since our last inspection.

Staff did not follow guidance published by NICE or the RCEM. There was no methodical assessment of pain in adults or children. Pain scores were not used and early administration of pain relief by the triage nurse rarely occurred during our inspection. No pain audits were carried out to monitor whether pain relief was adequate.
Patient outcomes

Managers did not monitor the effectiveness of care and treatment. They did not compare local results with those of other services to learn from them.

The urgent care centre was not included in national clinical audits, even when other areas of the trust, for example, the emergency department, were taking part. Audits that would have been relevant to the UCC were RCEM audit for vital signs in children 2015/16 and venous thromboembolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16.

There were no local audits of patient outcomes such as pain assessments, early warning scores or sepsis screening.

Unplanned re-attendance rate within seven days

From January 2017 to December 2017, the unplanned re-attendance rate to the UCC in the last 12 months was 3.7% which is better than the national average. This can be an indicator of effective care and treatment.

Competent staff

Staff were not always competent for their roles. Managers did not always appraise staff’s work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service. The learning needs of staff were not fully understood. Some nursing staff did not have the right skills or knowledge to do their job and some had not been appraised in the last year.

There was no orientation programme for staff who were new to the department. Nursing staff rotated from the emergency department at the Lister hospital and it was thought that they would have all the knowledge and skills necessary. However, experienced staff told us that there were differences in practice because they were not part of a fully equipped emergency department. For example, nurses at the UCC assessed and treated children older than one year. This did not happen in the emergency department because there was a separate children’s emergency department. Staff in the UCC had not been trained in the assessment and treatment of sick children and there was no systematic way of updating new staff of other differences in practice.

Triage training for the nursing staff was at 100%. Competencies were assessed in relation to triage assessment. Despite this training we found that nurses were not familiar with all aspects of the triage system used in the UCC. A course had been provided in relation to communication and behavioural challenges in mental health patients. Training was also provided in the care of patients living with dementia. However, only 30% of nurses had attended.

There was no formal competency framework but staff were given opportunities to develop professionally. For example, four nurses had commenced the course to become advanced nurse practitioners and others had started the non-medical prescribers course for minor illnesses.

Emergency medical technicians had completed training in cannulation, phlebotomy, wound care, suturing and plastering. They had a detailed competency workbook which was signed by a senior
member of staff once they had been assessed as competent in each skill.

**Appraisal rates**

From April to October 2017, 71.8% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 90%. A split by staff group can be seen in the table below. The trust were unable to split the training data between the UCC and the ED at Lister Hospital, so the graph shows the whole of the emergency division.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>93</td>
<td>125</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>24</td>
<td>35</td>
<td>68.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**

There was good multidisciplinary working where the staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

There were good working relationships with the co-located GP service, with community services and with the emergency department at the Lister hospital in Stevenage. Practitioners discussed complicated injuries or X-rays with a senior doctor at Lister Hospital and arranged transfers for patients with more serious conditions.

Direct referrals were made to physiotherapists for conditions such as soft tissue injuries or ligament strains. There were therapy departments based at the hospital which enabled face-to-face discussions about individual patient’s needs.
Emergency nurse practitioners referred patients directly to specialist doctors in orthopaedics, ophthalmology and plastic surgery in accordance with agreed clinical pathways.

There were effective links with other services such as health visitors, mental health teams, sexual health clinics, district nurses, and social services.

**Seven-day services**

*The service was available seven days a week and was always supported by easily available imaging and pharmacy services.*

The UCC was open seven days a week for 24 hours a day.

Imaging facilities were available every day from 8am to 11pm.

There was an on-site pharmacy available at the hospital from Monday to Friday 9am to 5pm and staff had access to a weekend pharmacy at the Lister hospital from 10am to 4pm. Outside of these hours staff had access to an on-call pharmacist for advice.

A stock of frequently required medication was kept in the unit which could be dispensed to patients when the pharmacies were closed.

**Health promotion**

There was a wide variety of health promotion posters and leaflets for people to read and take away with them. These included smoking cessation, drug and alcohol dependency and dementia. We observed people reading the information and taking leaflets away with them.

Staff told us that they would liaise with a patient's GP if an injury had been sustained that would affect a patient's independence.

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

*Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.*

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patient's consent was obtained in line with hospital policy and statutory requirements. We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.

Consent forms were available for people with parental responsibility to consent on behalf of children. The nursing staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant...
children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child’s parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

The staff we spoke with had sound knowledge about consent and mental capacity. Although practitioners had not been trained to undertake formal mental capacity assessments, none could remember an example of when this was needed. They were able gain telephone advice from local psychiatric crisis teams if this was necessary.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, completed within a standard template. However, the trust had not provided any data relating to Mental Capacity Act and Deprivation of Liberty Safeguards training completion. They told us that it was included within safeguarding training.

*(Source: Trust Provider Information Request P14/P49)*

The staff we spoke with had sound knowledge about consent and mental capacity.

## Is the service caring?

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed staff introducing themselves and explaining what was about to happen before examining patients.

Confidentiality was maintained at the reception desk by means of signs asking people to stand back from the desk when someone was being registered. The UCC had examination and treatment rooms with doors to ensure privacy when patients were being examined. We saw that staff knocked and waited to be called before entering.

All staff wore name badges which clearly stated their name and role. This helped to ensure that patients were aware of the professionals involved in their care.

We saw several examples of patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and made allowances when people were distressed or worried.

Parents were involved in the assessment and treatment of their children and clear explanations were given. We spoke with two patients and their families. They all reported a positive experience.

Results from the Friends and Family test for the year ending February 2018 were consistently good. They showed that 88% of people would recommend the UCC. This was similar to most other urgent and emergency services in England. However, response rates were low (1.5% of attendances) and so it was difficult to know how representative these views were.
Emotional support

**Staff provided emotional support to patients to minimise their distress.**

We observed the effective use of humour to distract patients who were upset. All staff, including receptionists, prioritised any patient who was obviously in pain or distressed for other reasons.

Staff that we spoke with were aware of the impact that a person’s treatment, care, or condition could affect them both emotionally and socially. They gave open and honest answers to questions and provided as much reassurance as possible. We saw that patients who needed extra time for their treatment due to communication needs were supported by staff.

Understanding and involvement of patients and those close to them

**Staff involved patients and those close to them in decisions about their care and treatment.**

Patients and their families told us they were kept informed of all care and treatment due to be carried out. We heard staff updating relatives about patients’ progress whilst maintaining confidentiality. Communication with children was age appropriate and effective. We observed a nurse holding the hand of a distressed patient while they explained what was happening and how they were going to try to make things better.

We spoke with two patients as they left the unit. They had all been given advice about what to do when they were at home. One had been given information leaflets to reinforce verbal advice.

Is the service responsive?

**Service delivery to meet the needs of local people.**

Patients could access the service when they needed it. However, the service did not always plan and provide services in a way that met the needs of local people. There had been a recent change to the service at night which was causing confusion for patients.

Very few people attended the UCC with a minor illness between midnight and 7am. In the week before our inspection there were between zero and four patients each night. As a result, the GP was withdrawn between these hours. The emergency nurse practitioners were qualified to treat patients with minor illnesses but had been told that they could not do this at night. Instead, patients were told that they had to ring the 111 service to find out if they could be seen by an out-of-hours GP who was based in a different part of the hospital. Staff told us that patients who attended at night were dissatisfied with these arrangements. Patients had made verbal complaints to staff in the UCC and had been encouraged to speak to the patient advice and liaison service. Staff had not been told whether formal complaints had been received from patients.
Meeting people’s individual needs

Overall, staff took account the needs of different patients including those in vulnerable circumstances.

The unit was well signposted from the entrance to the hospital site. Patients told us that it was easy to find. There was a drop-off point immediately outside and wheelchairs were available just inside the entrance. This meant the patients with leg injuries or limited mobility could access the unit easily. The UCC was on a single level and there was sufficient space for wheelchair users to move around easily. There were designated disabled parking bays outside the unit and there was always one available during our inspection.

Staff that we spoke with demonstrated a good understanding of the requirements of patients with complex needs. There were close links with community services to provide support.

Some staff (30%) had received training in the care of patients with dementia. They were able to describe the care and treatment of patients with a learning disability, or living with dementia who had recently attended the department. They recognised that the hospital environment could be confusing and distressing and so gave priority to this group of patients. The computer system featured a flagging system for patients with communication difficulties, so that staff could be alerted to their particular needs. This included patients living with dementia or with a learning disability.

The individual needs of children were not always met. Children had to wait in the general waiting area and there were no toys/activities to keep them occupied. Treatment areas were not child friendly. There were no toys or other means of distracting children who were distressed as result of injury or illness.

Translators could be accessed via the telephone translation system provided by the hospital. Staff told us that a translator was usually available within minutes, whichever language was required. Information leaflets were available in Polish and Romanian, both of which were frequently spoken in the local area.

Staff gave information leaflets to patients that clearly stated who they should contact if they had any concerns or worrying symptoms after treatment. There was information throughout the department relating to support groups for patients with specific conditions to access local support networks.

Access and flow

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.

Staff at UCC were unable to tell us how many patients were treated within one hour. Data received later from the trust stated that the median time to treatment for patients with minor injuries was 19 minutes (year ending February 2018).

There was a clear escalation plan which described the actions to be taken if patients were waiting more than two hours to be treated or if there were more than 20 patients waiting to be seen. Staff told us that this very rarely happened.
Percentage of patients that left the centre’s urgent and emergency care services before being seen for treatment

0.5% of patients in the UCC left without being seen (an average of 18 per month). This was better than the average of 3% for other urgent and emergency services in England in the same time period.

Learning from complaints and concerns

Summary of complaints
The service treated concerns and complaints seriously and investigated them in a timely manner. However, lessons learned from investigations were not always shared with all staff. From November 2016 to November 2017 there were 23 complaints about the UCC. The trust took an average of 30.7 working days to investigate and close complaints. This is in line with the trust’s complaints policy, which states complaints should be closed in 30 days.

Complaints were most commonly related to treatment received and communication. Staff were not routinely involved in responding to complaints or in devising changes to practice in order to prevent further complaints. Therefore, there was no evidence of learning from complaints.

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

Is the service well-led?

Leadership
There was confusion about who was responsible for the service and managers were not involved in its operational management. Therefore, it was not possible to know whether the right managers had the right skills and abilities to run a service providing high-quality sustainable care.

The urgent care centre (UCC) was part of the medical division of East and North Hertfordshire NHS Trust. This included the emergency department at the Lister hospital and nursing staff reported to the matron for the emergency department and urgent care. Staff that we spoke with in the UCC and the wider medical division gave us conflicting information about the leadership of the UCC. When we asked a consultant at the emergency department about input into clinical practice at the UCC we were told that it was “GP-led” and that medical staff at the emergency department were not involved. The nurses that we spoke with in the UCC were very clear that they were part of the emergency department.

We asked the trust for a copy of the service level agreement (SLA) between the GPs’ organisation and the trust. SLAs normally describe which organisation is responsible for each part of a service. Instead, they sent a heads of terms document that was drawn up when the UCC was commissioned. It stated that the GPs would be acting as sub-contractors to the trust and would not
be leading the service. The document goes on to state that: “For the avoidance of doubt, the Trust shall be responsible for the running of the UCC.” (Paragraph 4.3)

Nursing staff at the UCC rotated from the emergency department at Lister hospital and saw the matron in that setting. However, staff told us that the demands of the emergency department were extensive and so there was little time for the matron to visit the UCC. Staff we spoke with could not remember the last time the matron had visited. They felt that the leaders of the emergency department had little understanding of the different types of practice that took place at the UCC. There was no identified clinical lead, for either medicine and nursing, despite this being recommended by the Royal College of Emergency Medicine and the Faculty of Emergency Nursing (Unscheduled care Facilities – July 2009). We found similar issues during our last inspection and there appeared to have been no improvement.

We asked to see the matron responsible for the UCC but were told that they were on leave. We were able to see the newly-appointed matron for practice standards in the Lister Hospital emergency department. They had been in post for five weeks but had not worked at the trust before and so were unfamiliar with the arrangements at the UCC. We were told that the role of lead emergency nurse practitioner was about to be advertised. It was anticipated that the post-holder would spend equal amount of time at the UCC and emergency department and would lead advanced practice at both sites. It was not known when the new role would commence.

Day-to-day leadership of the UCC was the responsibility of the one of the two ENPs (Emergency nurse practitioners) on duty. During our inspection we observed that they concentrated on treating patients with minor injuries rather than having an overview of the whole department. On one of the days of our inspection the nurse in charge was unaware that patients were not being triaged during lunchtime, leading to delays in clinical assessment. A nurse who was new to the department had not been trained in triage and could not take over the assessment of patients when the first nurse went for a lunch break. The nurse in charge was unaware of the skills of each member of staff and had not taken action to prevent delays to patients.

There was a clinical site manager/senior sister for the QE11 hospital as whole. They visited the UCC once or twice a day and staff valued their support. However, this role did not have direct management responsibility for clinical practice in the centre and could only have a limited impact on patient care.

Vision and strategy

There was no vision for what the UCC wanted to achieve or workable plans to turn it into action.

Staff knew that the aim of the trust was to deliver quality health care that was trusted and valued. They were unaware of any specific strategy for the UCC. We asked the trust to send us a copy of the strategy or vision for the UCC and were told that it was the same as the trust strategy. However, urgent care did not feature in the trust strategy.
Culture

The senior staff responsible for the service did not appear to promote a positive culture that created a sense of common purpose based on shared values. They very rarely spent time at the centre and there were elements of a top-down and directive culture. For example, changes to the triage process had taken place the week before our inspection, apparently following a complaint. The changes meant that it took longer to assess patients and that clinical staff no longer had line of sight of patients in the waiting room. Staff working in the centre were concerned about the changes but did not feel able to challenge them. They did not know who had made the decision or the reasons behind them. The staff we spoke with had been told about the change during verbal handover sessions. No-one could find any written record of the decision. Staff felt that their work at the UCC was ignored by their managers and that senior staff were unaware of the type or quality of patient care that took place. This was similar to the findings of our last inspection.

Staff that we spoke with told us that, on the whole, they enjoyed working at the centre and several of them had been doing so since the centre opened. They felt that they were supported by their peers and other departments within the QE2 hospital. They told us that small numbers of staff produced a good sense of teamwork.

Governance

Governance systems had deteriorated since our last inspection. There was no systematic approach to continually improve the quality of services or safeguarding high standards of care.

In 2015, shortly after the centre had opened, there had been weekly meetings where risks, activity and clinical updates had been monitored and discussed. These no longer took place.

We asked the trust for results of any quality monitoring that had happened. They described audits that were planned for hand hygiene, pain assessment, documentation, safeguarding assessments, imaging and quality. There were no dates for the start of the audits and staff we spoke with were unaware of them.

We asked to see minutes of governance meetings involving the UCC. We were sent minutes of meetings described as “QEII UCC Meeting” which were chaired by the general manager for emergency care. These took place monthly and monitored GP activity and explored options for extending it. Complaints and incidents were mentioned but only if they referred to patients seen by a GP. Clinical standards and practice were not discussed and no clinical staff from the UCC were present.

Some of the sickest patients were jointly care for by nursing staff employed by the trust and GPs employed by a different organisation. We separately asked nurses and a GP about who would be responsible for the patient if a complaint was received or an incident occurred. None of the staff that we spoke with knew who would be responsible. We asked to see the service level agreement (SLA) between the trust and the organisation that supplied the GPs. An expectation would be that governance arrangements and responsibilities would be to be set out in an SLA document. Staff told us that the document could not be found. However, they sent us a heads of terms agreement
drawn up in 2014, before the UCC opened in 2015. This did not contain any information about governance arrangements and we were not assured that there were any clear lines of responsibility.

Management of risk, issues and performance

There were not effective systems in place for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Systems to identify risk were not effective. No-one that we spoke with could describe plans to reduce or eliminate risk. The UCC did not have a risk register. Risks that we had identified did not appear on the emergency department risk register or any other risk register. These included lack of training and competency in level three safeguarding and sepsis, delays in initial assessment and lack of oversight of patients in the waiting room. Staff in the centre had identified risks associated with patients presenting with a minor illness at night, but did not know how to assess the degree of risk.

Staff were familiar with the trust’s major incident plan which stated that the ambulance service may bring patients with minor injuries to the UCC. However, the major incident plan did not include action cards for staff at the UCC. This meant there was no guidance for the nurse in charge of the unit in the event of mass casualties being brought to the centre.

There was no clear guidance to follow in the event of unexpected disruptions such as a power failure, loss of water supply or flood. Staff told us they would contact the site clinical lead or site manager for help. However, there was no business continuity plan to assist the clinical lead in responding to serious and unexpected events.

There were no established processes for the management of current and future performance. Minutes of the last two management meetings were focussed on recently announced government plans for urgent treatment centres and how this might affect the GP service. There was no discussion of how patients’ needs were being met or the clinical performance of the unit.

Information management

The service collected and managed information to support activities, using secure electronic systems with security safeguards. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure. Paper records were supervised at all times and were sent to secure off-site storage when they were no longer required.

Computer systems captured information such as the time it took for patients to be assessed and treated. However, staff could not demonstrate that this was used to assess performance at different times of the day or different days of the week.
Engagement

Managerial engagement with staff was poor. Managers spent very little time at the UCC and there were no staff meetings regarding the service. Staff felt that their work at the UCC was ignored by managers.

The department engaged with public by taking part in local Healthwatch surveys. One survey took place at the beginning of March 2018, looking at the experience of patients who attended the UCC.

The centre took part in the national Friends and Families test and results were displayed in public areas.

There were no regular staff meetings. We asked to see minutes of the last two staff meetings. We were sent minutes of a sisters’ meeting from the ED that had taken place in February 2018. The minutes did not mention any previous meetings and it was not clear how information discussed at the meeting would be disseminated to other staff. Topics discussed at the meeting were entirely focussed on the role of the sisters in the emergency department. There was no mention of staff or patients at the UCC.

Learning, continuous improvement and innovation

Although there had been some improvements since our last inspection, many of them were dependant on recommendations from external agencies rather than internal improvement programmes.

There were some signs that the UCC had started to improve services by learning from when things went well and when they went wrong. There had been some improvements since our last inspection. Storage of medicines and infection prevention practices had improved and more staff had been trained in children’s safeguarding.

However, some areas of practice had deteriorated. These included delays for triage assessments, resuscitation training (particularly for children), the availability of clinical guidance for staff, the assessment of pain and governance arrangements.

Some practitioners were able to treat fractured wrists using an innovative regional anaesthetic technique. This prevented patients having to be transferred to the emergency department.