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

The East and North Hertfordshire NHS Trust provides a wide range of acute and tertiary care services from four hospitals, namely the: Lister in Stevenage; New Queen Elizabeth II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre (MVCC) in Northwood, Middlesex.

The area served by the trust for acute hospital care covers a population of around 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The MVCC provides specialist cancer services to some two million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

Since October 2014, the Lister has been the trust's main hospital for specialist inpatient and emergency care. The New QEII hospital opened in June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent care centre. Hertford County also provides outpatient and diagnostic services. The MVCC provides tertiary radiotherapy and local chemotherapy services.

Through the Lister, QEII and Hertford County hospitals, the trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. The trust is also a provider of children’s community services.

The trust has five clinical divisions - Medical, Surgical, Cancer, Women’s and Children’s and Clinical Support Services, each led by Divisional Director, Divisional Chair and Head of Nursing. These are supported by a corporate infrastructure.

(Source: Routine Provider Information Request (RPIR) – Context acute)
Acute hospital sites at the trust

A list of the acute hospitals at East and North Hertfordshire NHS Trust is 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>
</tr>
</thead>
<tbody>
<tr>
<td>Lister Hospital</td>
<td>Coreys Mill Lane, Stevenage, Hertfordshire, SG1 4AB</td>
<td>There are specialist sub-regional services in urology (including robotic surgery) and renal dialysis.</td>
</tr>
<tr>
<td>The QEII Hospital</td>
<td>Howlands, Welwyn Garden City, Hertfordshire, AL7 4HQ</td>
<td>-</td>
</tr>
<tr>
<td>Hertford County Hospital</td>
<td>North Road, Hertford, Hertfordshire, SG14 1LP</td>
<td>-</td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>Rickmansworth Road, Northwood, HA6 2RN</td>
<td>The centre has the latest pumps for the delivery of chemotherapy and in radiotherapy the most up to date linear accelerators deliver the latest treatment techniques.</td>
</tr>
</tbody>
</table>

The trust also provides renal dialysis services at two satellite sites in Harlow and Bedford.

(Source: Trust Website / Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led

Leadership

Leaders had the skills and abilities to run the trust and its services. They understood and managed the priorities and issues the trust faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

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 June 2018)
- Chief people officer (appointed in June 2019)
- Director of finance (appointed in October 2016)
- Five NEDs

Following on from our last inspection, the trust had made a number of appointments to the senior leadership team. This included the chief people officer, chief information officer (June 2019), director of estates (due to start post in November 2019) and associate director of quality and patient safety (November 2018). There had also been changes in leadership in divisional and heads of department level. This meant that whilst the leaders had the skills, knowledge and experience required and they still had some work to do in becoming a collective leadership team who understood the unique qualities and needs of their team. Our interviews with the executive team demonstrated that the trust were aware of this challenge and had embarked on a programme of development exercises for the senior leadership team which was on-going at the time of the inspection. Senior leaders we spoke with confirmed that this was an effective process which was allowing the team to develop the relationships that would see them become a collective leadership team that would deliver the strategic objectives.

Leaders understood the challenges to quality and sustainability and identified actions needed to address them. However, some actions were either challenging to embed effectively for complex reasons and some actions that should have been embedded were not. Overall, the trust leadership team demonstrated a good level of awareness of the priorities and challenges facing the trust. Executive leaders spoke about these challenges, which included improving the patient safety culture, the future of Mount Vernon Cancer Centre (MVCC), embedding the learning from never events and recruitment and retention of staff. There was an acknowledgement from senior leaders that some of the challenges required support from the wider system to address such as access and flow and the trust was working with partners to develop integrated care systems. The senior executives were clear about the actions that were already being taken to address a number of issues that we found at core service inspection. This included the work of the patient safety and quality team whose key priority was to improve the patient safety culture in the organisation. This team had been introduced since our previous inspection in March 2018 identified significant patient safety concerns. The patient safety and quality team were a multi-disciplinary team which included the associate director of patient safety and quality, a quality improvement matron, consultant anaesthetist, risk and assurance managers and clinical divisional quality improvement leads. Senior leaders were clear that the work needed to embed the necessary changes for an environment of continual improvement had to be inclusive, measured and sustainable. Senior leaders explained how the level of acceptable risks for the organisation had been established
through assessment processes and how these were being managed. An example of this had been the delay in implementing NEWS2 until 85% of staff had been trained in using this tool to identify the deteriorating patient. A further example was the setting of a target for infection prevention and control target of 80% which they recognised may lead to core service inspection teams seeing some deficiencies in infection control practices. There were clear plans in place to address these and to increase the number of staff trained. The executive leaders were aware that their previous focus on financial challenges had impacted upon the culture of the trust. They were committed to now shifting this culture to empower staff and to improve patient care through this route whilst maintaining financial control.

There were clear priorities for ensuring sustainable, inclusive and effective leadership capacity which included succession planning. The senior leadership team had invested in programmes for the development of leaders. These include ‘Learning to Lead’ for consultant staff and non-medical leaders above band 8A and above. This programme aimed to support identified staff become effective healthcare leaders in a rapidly changing and challenging environment. A programme called ‘Leading for Excellence’ for aspiring clinical directors to deliver high quality care within a strategic environment. Our interview with the recently appointed chief people officer and other members of the executive team, demonstrated that the trust leadership team were committed to developing an inclusive leadership development and talent management programme for staff at all levels. This was to form a part of the new ‘People Strategy’ which was in draft at the time of the inspection. Senior leaders told us that succession planning was a key part in planning delivery of the trust’s strategy. There had been a focus on identifying what kind of leaders the trust would need in the future based on the strategy and national objectives. The trust had worked with external organisations to help identify future leadership qualities. An associate director for leadership and talent management had been appointed in July 2019 to work with the chief people officer to develop and implement that part of the trust’s developing ‘People strategy’. The trust also played an active part in the STP’s regional talent board which was chaired by the trust CEO. This meant that as part of talent management and succession planning developmental opportunities such as the regional Accelerated Directors Development Scheme were accessed by suitable candidates at the trust.

**Board Members**

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 57% were female. Of the non-executive board members none were BME and 43% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>57%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>43%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

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 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. We checked five sets of directors personnel records and found that all the employment files were compliant with the Fit and Proper Persons Requirement. This was an
improvement from our previous inspection. There was a clearly defined policy in place, dated November 2017 to govern this process. 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, NEDS and executive directors made an annual declaration to confirm that there was nothing that would affect their fitness as a director of the trust.

Leaders were working hard to be visible throughout the organisation. During the core services inspections, the majority of staff told us that leadership visibility had improved. Members of the executive team regularly worked at different sites to make themselves available to staff. For example, the associate director of corporate governance and medical director aimed to work at MVCC at least once a week.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At our previous inspection the trust were in recovery mode from the financial pressures and challenges of implementing a new electronic patient record system across the trust. They had developed a short-term strategy which had been further developed into their new five-year strategy implemented in 2019. This was launched in April 2019 and covered the period 2019 - 2024. This included a new vision for the trust, which is “Proud to deliver high-quality, compassionate care to our community”. The strategy was developed with engagement from trust staff, patients and partners. The vision was supported through five key strategic priorities.

These strategic priorities were:

- **Quality** – We deliver high-quality, compassionate services consistently across all our sites.
- **People** – We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.
- **Pathways** – We develop pathways across care boundaries, where this is in the best interests of patients.
- **Ease of Use** – We redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.
- **Sustainability** – We provide a portfolio of services that is financially and clinically sustainable in the long term.

Underpinning the priorities were the trusts values of ‘Patients, improvement, value, open and team’ (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 trust had a number of strategies underpinning the overall strategy to support overall delivery of objectives. This included a quality strategy (2019-2024) to enable and support delivery of the trust overall strategy and sustainability. The quality strategy was approved by the board in May 2019 and identified four quality priorities for the organisation for the immediate 12 months. The four quality priorities were:

- Valuing the basics
- Patient and carer experience
- Keeping our patient safe
- Quality governance

Divisional teams reported to the senior management team around these four pillars.

Valuing the basics included having robust data on harm free care, infection prevention and control, safeguarding children and adults and medical devices and equipment management. The trust had made significant improvements with developing information technology (IT) systems to enable greater oversight of performance and accountability in this area since our last inspection. An integrated electronic dashboard had been created for all divisions which was interactive and included validated data in key areas of performance including harm free care. During our inspection, we saw that many teams were already using this dashboard, however this was not consistent in all areas. Our interviews with senior managers in the IT department demonstrated that teams were being supported with training and guidance to ensure that the dashboard was utilised effectively.

Patient and carer experience included responsiveness to complaints, improved local feedback, delivery of the carer’s pathway, increasing use of volunteers and improvements to the end of life care pathway. Within the end of life care pathway the trust had introduced butterfly volunteers to sit with patients who were at the end of their life so that no one died alone and relatives and carers were able to have some time away from their loved ones bed.

Keeping our patient safe included patient harm reviews, mortality reviews, improved sepsis and deteriorating patients identification and treatment as well as undertaking the getting it right first time initiative. Since our last inspection the trust had improved its Hospital Mortality Standardised rate to 12 which was below the national average and had it had been 300 days since the last never event.

Quality governance included strengthening audit and triangulation of other factors, as well as strengthening serious incident investigation and learning of lessons throughout the hospital.

During our inspection, we saw many posters and leaflets throughout the hospitals displaying the trust values and five year plans. This enabled staff to talk with our inspection team about the five-year strategies, the vision and the values.

In terms of the five key strategic objectives the board had taken the approach to focus on a limited number of areas to drive improvement. Board members were able to give examples where the focused approach was producing sustainable results across the five strategic priorities.

For example under the people priority the trust was working towards better recruitment, retention and leadership. We saw that this focused piece of work was having some effect by driving vacancy rates down to 8%, attrition rates were improving as were sickness and agency usage was declining. The culture of the trust had begun to change from a top down to an empowerment model and this had encouraged leaders to develop their own services. Board members were able...
to give examples where the focused approach was producing sustainable results across the five strategic priorities.

The trust had focused the previous years on the financial pressures and changing hospitals programme. However, they recognised that this had been inward facing and appointed a Director of Strategy to engage with other stakeholders in the Sustainability and Transformation Partnership (STP). The STP has developed a clinical strategy which sets out the plan for integration and sustainable, high quality health and care in order to address three key issues of: a health and wellbeing gap; a care and quality gap; and a funding and efficiency gap. The trust has a number of clinical leaders engaged in discussing the contributions from each provider and how to deliver the ambitions of the STP. Each division had a clinical strategy which was aligned to the strategy for the trust and for the STP. For example, the medical division had a strategy which enabled patients to stay at home longer and the surgical division to undertake more day case procedures. This ensured that healthcare focus was in the patients’ home and community rather than traditional models of care.

During our core service inspection, we highlighted some issues at the MVCC. We discussed these with the senior leadership team and found that discussions were being held at a cross regional level to address the issues in order to provide the most appropriate service to patients from across Hertfordshire and London.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work, and provided opportunities for career development. The trust worked hard to promote an open culture where patients, their families and staff could raise concerns without fear.

The senior leaders recognised the importance of a shift in the culture within the trust from a grip and control to empowerment of staff. They recognised that a grip and control strategy had served its purpose to bring the finances under control and that this had worked but that now that they had strategies in place to manage their finances appropriately the focus was now to empower divisional leaders and junior leaders within the organisation to manage and identify areas for improvement within their own teams. Whilst a number of staff we spoke with at the well led inspection reflected this change it was not always felt within the wider workforce. Board to ward frameworks had been developed and used to support this shift in culture.

Staff Diversity

As of 31 March 2018, East and North Hertfordshire NHS Trust employed 5,877 people, of which:

- 78% were women.
- The highest proportion of staff were aged between 25 and 59 years of age. Around 8% of staff were aged 60 years or above.
- 29% of staff were from Black Minority and Ethnic Communities.
- Less than 2% of staff declared to have a disability, around 55% of staff told us they don't consider themselves to have a disability with the remainder either unknown or have chosen not to disclose.
- 68% of staff have disclosed as Heterosexual and 2% as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose.
- Around 45% of staff consider themselves Christian and around 10% as Atheists.
- Around 10% chose not to disclose their religion or belief.

(Source: Trust Equality and Diversity and WRES Annual Report 2018)

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity and inclusion
- Health and wellbeing

(Source: NHS Staff Survey 2018)

The staff survey shows that the trust was around the median for trusts in England over the above 10 key questions. The number of staff responding to the survey had risen from the previous year from 29% to 43%. The survey had been offered both electronically and in paper format which potentially allowed a greater number of people to complete this. Following the previous survey the trust had undertaken a number of actions including fortnightly staff engagement sessions, divisional action plans and staff experience user groups. This had shown improvement in six of the
measures and statistically significant change in two measures including staff health and wellbeing and equality diversity and inclusion.

In response to this most recent survey the trust planned again to develop divisional action plans and to hold focused intervention groups whilst including the Listen Empower Nurture and Develop programme into board development. The LEND programme was now being expanded to leaders at all levels to ensure that staff felt engaged in the development of the trust. The trust were also reviewing the communication plan to ensure that they reached as many staff as possible. They were trying different ways of reaching people. They had moved from a daily email to all staff to review the implementation of electronic systems which staff could receive on their personal mobile phones.

The divisional and leadership team were aware of the mixed culture within the organisation as the trust started to move from a grip and control to an empowerment culture. However, we heard from union representatives that the culture had yet to change in all areas. They were concerned about a bullying culture in which staff felt that they had to do as they were told. There was a recognition at the senior leadership team that this was still an issue in some areas. Union representatives felt that they had a good working relationship with the new chief people officer who regularly attended regional union meetings and they had the opportunity to express their concerns in this forum. However, they expressed concerns that other members of the senior leadership team did not attend the whole meeting and therefore missed out on the concerns they raised. The director of nursing stated that she worked closely with regional representatives and that this was a challenging but supportive relationship. She acknowledged that there was more work to be done in supporting staff through investigations.

Our interview with the senior leadership team including the chief people officer and Freedom To Speak Up Guardian (FTSUG) demonstrated that the trust were committed to tackling instances of bullying and harassment. The trust had an action plan in place at the time of our inspection which had been recently reviewed by the chief people officer. Updated actions to be included as part of the developing new trust people strategy was the introduction of learning sets for all employees in relation to bullying and harassment. A bullying and harassment toolkit to assist staff at all levels was being developed with union representatives which was due to be completed in December 2019. There was also an emphasis on empowering staff to challenge, and supporting staff at all levels to understand individual communication needs and human factors. The FTSUG was the associate director of governance who had been in the position for four years. All staff received information about the FTSUG at their induction and posters were displayed throughout the trust. Whilst being in this position meant that the FTSUG had easy access to executives to escalate concerns; they acknowledged that their position could potentially represent a barrier to staff raising concerns. To minimise this risk, the trust was in the process of establishing FTSU ambassadors throughout services to promote their function. In order to measure staff’s confidence in raising concerns the trust planned to undertake an internal audit in November 2019. The trust was developing a ‘Just culture’ working group to help promote a positive culture of openness and transparency which the FTSUG would also report in to.

The culture at MVCC was mixed. Senior leaders were aware of this and were taking actions to improve the culture. Before our inspection as part of routine engagement with the trust we undertook focus groups to get feedback from staff at locations throughout the trust including MVCC. All staff we spoke with were passionate and committed to providing compassionate and effective care to patients. Staff were also open about the challenges they faced due to the complex running of the service. The majority of staff we spoke with before and during our inspection felt that due to the distance between locations in the trust and the lack of executive
visibility they did not always feel a part of the trust. The estates at MVCC were managed by another trust and staff at all levels told us that this presented a challenge to ensure that environmental concerns were addressed when required. Most staff were positive that if the recommendations from a recent external review of MVCC were acted upon this would result in a sense of certainty for staff and patients. At the time of our inspection, the trust was taking part in system wide consultations with external partners including NHS England, specialist commissioners and other acute trusts to make joint decisions on the future of MVCC.

**Workforce race equality standard**

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

8. These scores are un-weighted, or not adjusted.

9. There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.

10. Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.

11. The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of March 2018, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (3.1% of BME staff compared to 6.6% of White staff). This decreased by 0.2% compared to/remained similar to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

- 35.2% of BME staff experienced harassment, bullying or abuse from patients, relatives or the public in the past year (2018 NHS staff survey) which was significantly higher when compared to 29.4% of White staff. The score had increased by 5.7% when compared to the previous year, 2017.
- 15.0% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 7.3% of White staff. The score had decreased by 0.2% when compared to the previous year, 2017.

There were no BME Voting Board Members at the trust, which was significantly different to the number expected, based on the overall percentage of BME staff.
Senior leaders acknowledged that they needed to understand how they could ensure that the leadership team was reflective of the workforce and population. Steps taken to address this issue included having a dedicated equality, diversity and inclusion manager (not yet in post at time of our inspection). There were BME and LGBT+ networks in place and the trust were in the process of setting up a women’s network. The trust had also undertaken a recent review of their educational and development processes to understand how accessible development actually was for all staff. Senior leaders also wanted assurances that staff at all levels had a good understanding and awareness of the importance of diversity and inclusion. The report and recommendations from the review were due to be completed October 2019.

Our interviews with key members of staff confirmed that the WRES and Workforce Disability Equality Standards (WDES) would form a key part of the people strategy in line with strategic objectives and trust values.

**Friends and Family test**

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 96.0% and 97.9% between June 2017 and May 2019.

The performance of this metric is not stable and may be subject to ongoing change.

From June 2017 to May 2019, the response rate for the Patient Friends and Family Test at the trust ranged from 39.5% to 49.1%.

**East and North Hertfordshire NHS Trust – response rate June 2017 to May 2019**
Sickness absence rates

The trust’s sickness absence levels from April 2018 to March 2019 followed a similar trend to the England average but rates were higher than the England average.

(Source: NHS Digital)

The trust were aware of the need to reduce staff sickness and had implemented a strategy to ensure that this reduced. They had reduced sickness from 4.8% to 3.5% and were coming into line with the national average. The senior leadership staff appreciated that this reduction in sickness meant that there were on average 55 more staff on the wards and recognised the impact of this on ward and departmental staff. The agency usage had also dropped from 1400 shifts filled in July 2018 to 300 shifts filled in July 2019. They recognised that this also had a positive impact on the wellbeing of staff.

The trust had a focus on the recruitment and retention of staff and had actively recruited 274 more staff into its workforce. Of this number 82 were nursing staff and 53 were medics. The trust had
focused on difficult to recruit to posts and had implemented a refer a friend scheme to drive recruitment.

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed worse than expected for one indicator (curriculum coverage) and the same as expected for the remaining 17 indicators.

- Better than expected
- Same as expected
- Worse than expected

<table>
<thead>
<tr>
<th>Survey area</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum coverage</td>
<td>☯</td>
</tr>
<tr>
<td>Educational governance</td>
<td>☐</td>
</tr>
<tr>
<td>Reporting systems</td>
<td>☐</td>
</tr>
<tr>
<td>Rota design</td>
<td>☐</td>
</tr>
<tr>
<td>Teamwork</td>
<td>☐</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>☐</td>
</tr>
<tr>
<td>Clinical supervision out of hours</td>
<td>☐</td>
</tr>
<tr>
<td>Handover</td>
<td>☐</td>
</tr>
<tr>
<td>Induction</td>
<td>☐</td>
</tr>
<tr>
<td>Adequate experience</td>
<td>☐</td>
</tr>
<tr>
<td>Supportive environment</td>
<td>☐</td>
</tr>
<tr>
<td>Work load</td>
<td>☐</td>
</tr>
</tbody>
</table>
Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were generally clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, recent improvements to governance processes were yet to be fully embedded.

There were structures, processes and systems of accountability to support the delivery of the strategy and quality sustainable care. The trust reviewed their governance processes on an annual basis and made changes and improvements when required. Following on from our previous inspection, the trust had made some significant changes to the governance structure. This included the introduction of a new compliance team (September 2018) to work closely with divisional teams. However, some changes made in the 12 months before our inspection were not yet embedded throughout the trust. An example of this is the updated assurance systems from ‘ward to board’, which included strengthening quality governance systems through audit and triangulation. Throughout the core service inspections, we found examples where these systems were starting to have a positive impact, however these were still being embedded.

The board assurance framework (BAF) had been reviewed in May 2019 with the implementation of the new strategy.

Board Assurance Framework

The trust provided their Board Assurance Framework, which details three corporate objectives along with the risks that accompany each objective. A summary of these can be found in the table below.

<table>
<thead>
<tr>
<th>Risk reference</th>
<th>Risk description</th>
<th>Current risk</th>
<th>Target score</th>
<th>Date added</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)
<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001/18</td>
<td>01/03/2018</td>
<td>There is a risk that 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 standards.</td>
</tr>
<tr>
<td>002/18</td>
<td>01/03/2018</td>
<td>There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.</td>
</tr>
<tr>
<td>003/18</td>
<td>01/04/2017</td>
<td>There is a risk that the trust is unable to achieve financial performance in 2018/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.</td>
</tr>
<tr>
<td>004/18</td>
<td>01/04/2017</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 2018/19.</td>
</tr>
<tr>
<td>005/18</td>
<td>01/04/2017</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>
</tr>
<tr>
<td>006/18</td>
<td>01/03/2018</td>
<td>There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment.</td>
</tr>
<tr>
<td>007/18</td>
<td>01/03/2018</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>
</tr>
<tr>
<td>008/18</td>
<td>01/03/2018</td>
<td>There is a risk that the trust is not adequately prepared to deal with a major incident or emergency.</td>
</tr>
<tr>
<td>Date</td>
<td>Risk Description</td>
<td>Likelihood</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>013/18</td>
<td>There is a risk that the trust is adversely affected by the United Kingdom’s departure from the European Union, particularly in the event of no deal being secured.</td>
<td>16</td>
</tr>
<tr>
<td>014/18</td>
<td>There is a risk that the trust’s Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life.</td>
<td>20</td>
</tr>
</tbody>
</table>

**Corporate objective 2: New ways of caring**

<table>
<thead>
<tr>
<th>Date</th>
<th>Risk Description</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<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>16</td>
<td>01/03/2018</td>
</tr>
<tr>
<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>12</td>
<td>01/03/2018</td>
</tr>
<tr>
<td>011/18</td>
<td>There is a risk that the trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience</td>
<td>15</td>
<td>15</td>
<td>01/03/2018</td>
</tr>
</tbody>
</table>

**Corporate objective 3: Develop the Mount Vernon Cancer Centre (MVCC)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Risk Description</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<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>16</td>
<td>16</td>
<td>01/03/2018</td>
</tr>
</tbody>
</table>

Note: Risk scores are calculated by multiplying the likelihood (maximum of 5) by the impact (maximum of 5).

(Source: Trust Board Assurance Framework – April 2019)

Assurances were provided to the board through committees, sub-committees and reports. There were three main committees which reported directly to the board. These were the quality and safety committee, finance and performance committee and audit committee. Feeding into these three committees were a number of sub-committees including medicines optimisation, mortality surveillance and risk and quality committee. Our observations during inspection and review of documentation demonstrated that there was an acceptance that some areas could have a reduced level of assurance whilst fundamental changes were being implemented and embedded. For example, the trust reported that over the past year their infection prevention and control had...
improved and that the NHSI quality monitoring team had now rated them as Green. However, during the inspection we found a number of examples of poor infection control practices. The trust had set a target of 80% for training in infection prevention and control but recognised that this meant that one in five people had not received training. They were working towards having a culture where people felt able to challenge others when they saw poor practice but recognised that they were not there yet. Further examples were the lack of embedded learning from never events and continued poor practice in medicines management.

Since our previous inspection, the trust had reviewed the accountability framework and introduced monthly divisional accountability review meetings (ARM) where triumvirate leadership teams provided assurances to members of the board on key areas of performance. The ARM provided divisional teams the opportunity to advise on progress of action and improvement plans and to receive support and constructive challenge from members of the board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£420.3m</td>
<td>£444.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£24.5m)</td>
<td>(£13.2m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£444.8m</td>
<td>£458.0m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£7.7m)</td>
<td>(£0.3m)</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was lower than the previous year. Projections for 2019/20 indicate that the deficit will decrease to £0, which is the same as the projected deficit for 2020/21.

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

Senior staff recognised that the trust had moved from a financial deficit position to a more sustainable position. The senior team had better information and financial oversight to inform their decisions. The current leadership team recognised that by increasing recruitment and retention, changing the culture to empower staff this led to better patient outcomes and improved financial control. The reduction in patient harm, improved working with the STP and looking at new models of care enabled a better financial balance.
The board had an appropriate level of operational and financial experience to review and challenge through the relevant committees and sub committees. The board had strengthened the project management office (PMO) team to provide advice and support to projects undertaken by staff. However they recognised that whilst they required the PMO function they also needed to move to a transformation team using a QI methodology. This would support the move from a grip and control culture to a transformational model. Staff we spoke with stated that they found that the trust spent less time on the financial aspect and more time of patient safety which in turn delivered savings and better patient outcomes.

**Trust corporate risk register**

The trust provided a document detailing their 15 highest profile risks as at 14 May 2019. Each of these have a current risk score of 10 or higher (from a maximum possible risk of 25).

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Next review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5183</td>
<td>Risk that the trust does not hold a final verified copy of medical correspondence</td>
<td>12</td>
<td>13/08/2019</td>
</tr>
<tr>
<td></td>
<td>Medical correspondence currently stored as word documents. No formal sign-off process to ensure that saved copy is correct. Limited access control arrangements in place mean that documents can be edited after being sent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5837</td>
<td>General Data Protection Regulations (GDPR)</td>
<td>12</td>
<td>13/08/2019</td>
</tr>
<tr>
<td></td>
<td>On 25 May 2018 the trust is required to have implemented the new GDPR. Under the new GDPR there is a statutory requirement to have a Data Protection Officer (DPO). Failure to implement GDPR and have in place a DPO may result in regulatory action against the trust by the statutory body (ICO) up to £17 million.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5979</td>
<td>Partial compliance with Patient Safety Alert 2016/006 NG Tube misplacement</td>
<td>10</td>
<td>30/06/2019</td>
</tr>
<tr>
<td></td>
<td>Potential risk of feeding via NG tube when correct placement has not been accurately confirmed. Local audits indicate varying practices in relation to the documentation around NGT placement checking. Declaration of Never Event in October 2017.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5992</td>
<td>Staff communications - information and engagement</td>
<td>15</td>
<td>10/06/2019</td>
</tr>
<tr>
<td>ID</td>
<td>Description</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>5993</td>
<td>Through lack of information, trust staff are not kept aware of major changes that could prevent them from carrying out their work effectively.</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>5994</td>
<td><strong>Negative media (traditional and digital) commentary</strong></td>
<td>10/06/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Critical commentary of the trust, its services and staff, carried in the traditional and digital media has the potential to damage the trust's reputation and confidence in its services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5995</td>
<td><strong>External stakeholders/public losing confidence in the Trust and its services</strong></td>
<td>09/08/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Through lack of engagement, key external stakeholders - who influence the wider public locally - lose confidence in the trust and the quality of its services. Such lack of confidence could lead to lack of support for the trust, especially around changing existing services and developing new ones.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6033</td>
<td><strong>Accidentally administering medical air to a patient instead of oxygen</strong></td>
<td>10/05/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is a risk that medical air can be administered to a patient instead of oxygen. This is due to the difference between the air and oxygen flow meters being difficult to identify as they both have universal outlets. Oxygen tubing can be attached to both.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Patient Safety Alert NHS/PSA/D216/009 which came out on 4 October 2016 has not been fully implemented. NHS Improvement &quot;Supporting Information for Patient Safety Alert: Reducing the risks of connecting oxygen tubing to air flowmeters&quot; has not been fully implemented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6041</td>
<td><strong>Risk of further Never Events (NEs) due to the declaration of seven NEs between May 2017 and April 2018</strong></td>
<td>30/06/2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The trust has had seven NEs since May 2017. These were: retained suture needle (2017-13022), wrong finger surgery (2017-23685), failure to recognise misplaced NG tube (2017-27376), retained gall stones (2017-28026), wrong blood to wrong patient blood transfusion (2018-6882), CVC guide wire retained (2018-8164) and oxygen tubing connected to air (2018-8476). There is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6049</td>
<td>a risk of further NEs occurring if trust systems and processes are not checked robustly.</td>
<td>12</td>
<td>29/07/2019</td>
</tr>
</tbody>
</table>
| 6067 | **Clinical supervision of nurses - some gaps in demonstrating compliance**

The trust is unable to consistently demonstrate compliance with the requirements of clinical supervision across all its nursing workforce. | 10 | 13/08/2019 |
| 6173 | **Risk of patients not receiving urgent medical help due to the lack of emergency call bells in older wards in tower block**

There are no emergency call bells within the tower block apart from the new wards on 7BN and 7BS plus 11an and 11as. All wards do have the normal call bells and if there was an emergency the nurse what have to summons help verbally. The risk is increased at night due to fewer staff being around. This has been raised as a CQC area of concern. | 10 | 13/06/2019 |
| 6173 | **Risk of serious harm to patients with LD due to not receiving appropriate clinical care**

Increased risk of mortality for patients with LD where clinical care does not meet the needs of the patient, as highlighted in the National LD mortality review annual report 2018. Serious incidents have been reported in the trust since January 2017 for deaths of patients with LD. Themes in SI are:

1. Delays in treatment
2. Delays in escalating the deteriorating patient
3. Delays in recognising and treating sepsis
4. Delays in decision making for critical care input
5. Delays in the involvement of senior clinicians for decision making
6. Decisions made without full information about the patient's normal day to day condition
7. Patients not able to communicate with clinicians how they are feeling
8. Not utilising information from family or carers about the person or involving the family or carers in consultations to ensure person focused decisions
9. Poor communication between clinical teams
10. Patients with complex clinical needs and significant... | 10 | 13/06/2019 |
<table>
<thead>
<tr>
<th>Vulnerabilities and co-morbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Mental Capacity Act 2005 requirements not always understood or used effectively</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Training Programme (QTP) skills and knowledge to adopt improvement science tools and techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of insufficient skills and knowledge capability due to scale of the QTP impacting on the effectiveness of the programme.</td>
</tr>
<tr>
<td>This is a large programme of improvement, where adoption of improvement science at scale will be required. This will require a substantial training and development across many areas of ENHT workforce, to allow reliable delivery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QTP capacity of clinical teams to drive improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk to the success of the QTP due to limited capacity of clinical teams to drive improvement impacting on patient safety and experience.</td>
</tr>
<tr>
<td>Time in busy schedules, particularly of clinical team members, to accommodate improvement meetings, collect data, share learning and attend reporting assurance meetings may be a challenge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of doctor escalations in Nervcentre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk that doctors are not being informed of deterioration in patients condition due to doctors not using Nervcentre and receiving escalation notifications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increased escalations from Nervcentre to Critical care outreach team (CCOT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a risk that escalation alerts to CCOT are likely to increase. This is due to changes in the NEWS2 scores. CCOT will be informed of all patients with a NEWS score of five or above.</td>
</tr>
</tbody>
</table>

(Source: Trust Management Risk Register - May 2019)
The trust had reviewed the information provided to the risk and Quality Committee and refined this information so that it enabled a more robust approach to risk and quality. The meeting was based on the integrated performance report and a summary of this. The meetings started with a presentation by staff on an area of focus. The senior leadership team were clear that their risks consisted of recruitment and retention of staff alongside performance of the trust especially around referral to treatment times. The chair of the Risk and Quality Committee felt that they were provided with robust information on which to recommend follow through to the trust board. We reviewed the integrated performance report and found that this document was split into five areas including Safe and Caring, Effective services, Responsive services, Well Led and sustainable services. These minutes demonstrated that there was discussion on points of concern and that non-executive and other staff felt able to challenge the information provided to them. We found that relevant issues were discussed and staff presenting the reports were able to answer concerns and would listen to the suggestions of others. This was corroborated throughout our interviews with staff at the trust.

The Risk and Quality Committee also reviewed the Board Assurance Framework (BAF) and the Corporate Risk Register and discussed the risks they contained. The minutes demonstrated appropriate challenge on the length of time risks had been on the BAF and risk register as well as plans in place to mitigate the risks currently held by the trust. The trust had now put in place divisional quality managers who were working to ensure that the divisions worked to a consistent framework. These staff also monitored action plans to ensure that mitigating factors were undertaken in a timely manner.

The trust had a business continuity plan to be implemented in specific circumstances. During our inspection, the trust implemented their business continuity plan due to the extreme weather conditions. We saw that staff worked together to deliver services under challenging circumstances.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The board received information on quality and sustainability through committee reports and the review of the integrated performance reports at trust board meetings. Our review of trust board papers, meeting minutes and committee reports confirmed that quality and sustainability was discussed at all levels.

The trust had recently updated the information technology systems to allow greater oversight of performance in key areas. A single source of information had been created in an electronic dashboard. The IT team had developed a process to collate data into a single source from a variety of information systems across the organisation, which captured and recorded relevant clinical and demographic data about patients along their pathway. This had been a collaborative effort between clinical and non-clinical staff to design the dashboard to ensure that there was appropriate focus on quality and finance. This meant that teams and managers at all levels could easily access information related to service delivery including performance, governance and workforce metrics. There were clinical systems in place and also non-clinical systems in place that captured such areas as incident reporting; this directly contributed to improving the quality of care for patients.
Performance was measured at all levels of the organisation and the audit committee was responsible for producing an annual evaluation of the effectiveness of performance measuring tools.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Since our previous inspection the trust had had greater focus on joint working with partners through the Sustainability Transformation Programme (STP). Leader recognised that this joint working had taken some time to achieve momentum but now all leaders were actively involved in at least one working group within the STP. The trust had brought therapists from the community into the organisation in order that patients could be enabled to return home in a timely manner. The trust recognised that it was providing a traditional hospital model and was seeking new ways of working so that community partners did not need to admit patients in order to receive support and advice on the treatment of patients. Within surgery the trust was looking to move to an increased day case model with support in the community for patients. The trust was working with STP partners to achieve people receiving healthcare close to if not in their own homes. Senior leaders described working relationships as improving and that they shared a joint vision of what services may look like in the future.

Senior leaders and clinical divisional leaders undertook weekly walk arounds to encourage the engagement of staff and to listen to patients’ feedback. They also engaged in social activities occurring within the hospital to allow staff to access them with concerns or suggestions. The trust held weekly Friday at 8am meetings at which staff could engage with them and hear about what's new as well as discuss initiatives. This meeting is open to all staff and engages both nursing and medical staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff were being supported to have a good understanding of quality improvement methods and developing the skills to use them. Leaders encouraged innovation and participation in research.

Following on from our precious inspection in 2018, the trust had taken a number of actions to address the safety concerns that were raised and improve the quality of services. The trust had implemented a quality transformation programme in March 2018 to develop a quality strategy and re-design quality and safety governance structures including reporting and assurance frameworks. This included the introduction of a dedicated patient safety and quality improvement (QI) team in August 2018. The patient safety and QI team was led by an associate director and consisted of head of QI, deputy director of nursing, consultant anaesthetist, mortality improvement lead, QI matron and divisional quality managers. At the time of the inspection, the team was still recruiting to some key positions within the QI roles, specifically related to mortality. The team was focussed on strengthening the process of audit and triangulation to identify areas of improvement. For example, the team had taken themes from a number of areas including learning from deaths and patient safety incidents including never events to develop the trust’s safety checklists in line with National Safety Standards for Invasive Procedures (NatSSIPs – NHS England, 2015). The team
had also worked closely with the IT team to develop the holistic electronic performance dashboard. This had been a QI project to ensure that the focus of performance was an appropriate balance of quality and finance as the trust worked to move away from the ‘grip and control’ model. The team had organised the trust first trust ‘Quality learning event’ in June 2019. This had been a full day of learning and discussions around patient safety, human factors and the importance of engaging with QI methodology. A further event was planned for October 2019 focussed on NatSSIPs. The QI matron was developing an evidence-based clinical excellence framework that would be used to recognise excellence.

At our previous inspection, we found a number of concerns in medicines management. During this inspection, whilst we still found some concerns across the trust, we also saw that the trust had made some improvements and had a plan to continue making sustainable improvements. This included the chief pharmacist now becoming a member of the quality and safety committee to ensure effective escalation of medications issues. The trust had invested in ward-based pharmacists and staff told us that on eight wards this had a direct impact on access and flow. There was a plan to increase ward based pharmacists from 75% on all wards in 2019/20 to 80% in 2020/21. The trust was in the process of developing the medicines electronic dashboard which was due to be completed in October 2019 and give greater visibility to medicines optimisation and medicines management at all levels.

Through collaborative working of the trust’s sepsis, acute kidney injury, critical care outreach team and resuscitation teams the organisation has seen the introduction of face to face root cause analysis with local teams post cardiac arrests. This immediate learning had contributed to an overall 43% reduction of cardiac arrests (in non-critical areas). The deteriorating patient collaborative have currently analysed data to identify where 80% of cardiac arrests have occurred and escalation could have been strengthened, this improvement work and pilot area is in progress. The trust has presented this at local and national patient safety events and has submitted this for consideration at a number of national awards.

As part of Doctoral Studies, the trust sepsis lead nurse has presented their research and shared experiences on improving the care of patients with learning disabilities who develop sepsis in the Houses of Parliament which was considered in the development of the national agenda.

The trust learning disabilities team have been recognised nationally for their work in implementing the national standards published in 2018.

The trust was trialling a ward accreditation programme. Two wards had self-assessed themselves through a portfolio approach. This had brought teams together as every member of the team collected evidence for the portfolio. This assessment was then tested out. The ward accreditation programme included research and whilst this was in its infancy in some areas the trust had employed a professor to assist all grades of staff with this.

The trust has participated in 141 research projects and increasing numbers of patients, 3071, have been offered entry into research projects. These projects included a review of chemotherapy treatment finding that three months is as effective as a six-month course of chemotherapy. This produced positive outcomes for patients who were exposed to reduced cytotoxic therapies. It also included ear acupuncture for patients with prostate cancer to reduce pain. This service was expanded from the breast cancer services.

Complaints process overview
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>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>95%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>35</td>
<td>54%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>4,498 (April 2018 to March 2019)</td>
<td></td>
</tr>
</tbody>
</table>

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

Number of complaints made to the trust

From April 2018 to March 2019, the trust received a total of 968 complaints. The highest number of complaints were for outpatients, with 34.4% of total complaints, followed by medical care (19.4% of complaints) and surgery (11.3%).

<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>333</td>
<td>34.4%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>188</td>
<td>19.4%</td>
</tr>
<tr>
<td>Surgery</td>
<td>109</td>
<td>11.3%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>101</td>
<td>10.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>56</td>
<td>5.8%</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>5.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>45</td>
<td>4.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>38</td>
<td>3.9%</td>
</tr>
<tr>
<td>Community health services for children, young people and families</td>
<td>20</td>
<td>2.1%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>18</td>
<td>1.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>0.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

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

From April 2018 to March 2019, the trust received a total of 47 compliments. The highest number of compliments were for urgent and emergency care, with 36.2% of total compliments, followed by surgery (21.3% of compliments).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency care</td>
<td>17</td>
<td>36.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>10</td>
<td>21.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>9</td>
<td>19.1%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>5</td>
<td>10.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>3</td>
<td>6.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>1</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

The trust stated that compliments are received via the CEO Office and the responses are sent to the relevant areas by the CEO. They are then shared with the complaints team for recording. The trust received multiple compliments via social media platforms and also direct compliments to areas across the trust. The trust is currently developing a consistent approach that captures, records and shares themes and trends that relate to compliments and praise for its services.

The trust has identified the following themes relating to compliments received:

- Outstanding staff at the QEII Hospital from receptionists to midwives
- Comment with regards to joined up care between community and hospital
- Comment that although the department was very busy with patients waiting on the corridor the nurses delivered excellent care with a friendly greeting and an explanation as to what was happening
- Children’s A&E staff went the extra mile

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

Accreditations

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

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
<th>CQC core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Lister Hospital and QE2 Hospital endoscopy departments. Accreditation awarded 17/12/2018</td>
<td>AC - Medical care (including older people’s care)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>ISO 9094 histology - October 2018 (surv December 2018)</td>
<td>Other</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>CHKS ISO 9001, Mount Vernon Cancer Centre and the cancer services, July 2019</td>
<td>AC - Medical care (including older people’s care)</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Lister Macmillan Cancer Centre received this award on 12/07/2018.</td>
<td>AC - End of life care</td>
</tr>
</tbody>
</table>

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

Lister Hospital
Lister Hospital
Coreys Mill Lane
Stevenage
Hertfordshire
SG1 4ABH
Tel: 01438 314333
https://www.enherts-tr.nhs.uk

Surgery

Facts and data about this service

The East and North Hertfordshire NHS Trust provides a wide range of acute and tertiary care services from four hospitals, namely: Lister Hospital in Stevenage; New Queen Elizabeth II in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, Middlesex.

The area served by the trust for acute hospital care covers a population of around 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some two million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

Since October 2014, the Lister has been the trust’s main hospital for specialist inpatient and emergency care. The New QEII hospital opened June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent care centre. Hertford County also provides outpatient and diagnostic services. The Mount Vernon cancer centre provides tertiary radiotherapy and local chemotherapy services.

Through the Lister, QEII and Hertford County, the trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services to include the emergency department and maternity care, as well as regional and sub-regional services in renal medicine, urology and plastic surgery. The trust is also a provider of children’s community services.

The Trust has five clinical divisions - medical, surgical, cancer, women’s and children’s and clinical support services, each led by divisional director, divisional chair and head of nursing. These are supported by a corporate infrastructure.

At the Lister Hospital site there are 12 surgical wards which are; 11B, 8AN, 8AS, 8BN, 8BS, 7BN, 7BS, 5AN, 5AS, 5BN, 5BS and Swift ward. In addition, there is a Surgical Assessment Unit (SAU) which has 10 bedded side rooms, eight ambulatory spaces and one clinic room.

There are 17 operating theatres which include a day surgery unit, treatment centre and main theatres. There is also a post anaesthetic care unit (PACU) which has 26 cubicles and a pre-
operative assessment area. The trust also provides robotic urology surgery. ((Source: Routine Provider Information Request (RPIR) – Context acute).

During the inspection we visited the following locations:
- Wards 5A, 5B, 7B, 8A, 8B, 11B, SAU, the pre-assessment unit, Swift ward and theatres two, three, eight and nine.

The trust had 34,346 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 12,845 (37.4%), 17,570 (51.2%) were day case, and the remaining 3,931 (11.4%) were elective. (Source: Hospital Episode Statistics).

During the inspection, we spoke with 24 staff of various grades, including consultants, matrons, clinical leads, ward managers, housekeepers, pharmacists, therapists, and doctors. We spoke with five patients and their families and observed care and treatment. We looked at 17 patients' medical records and eight medication charts.

We attended a multidisciplinary team meeting, a daily huddle and a staff handover.

The service was last inspected in March 2018. At that inspection, the surgical service was rated inadequate for the safe, responsive and well-led domains, and effective was rated as requires improvement. Caring was rated as good. The overall rating for the service was inadequate.

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 but did not always make sure everyone completed it.

Mandatory training completion rates

Nursing staff received but did not always keep up-to-date with their mandatory training.

The trust set a target of 90% for completion of mandatory training. In surgery the 90% target was met for six of the eight mandatory training modules for which qualified nursing staff at trust level were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in surgery at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>329</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>317</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>319</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>315</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>315</td>
</tr>
</tbody>
</table>
Medical staff received but did not keep up-to-date with their mandatory training.

In surgery the 90% target was not met for any of the seven mandatory training modules for which medical staff at trust level were eligible. A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in surgery at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>253</td>
<td>287</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>212</td>
<td>287</td>
<td>73.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>253</td>
<td>287</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>186</td>
<td>287</td>
<td>64.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>251</td>
<td>286</td>
<td>87.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>251</td>
<td>280</td>
<td>89.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>214</td>
<td>287</td>
<td>74.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

The mandatory training was comprehensive but did not always meet the needs of patients and staff. Training courses were either completed online or at face-to-face learning sessions. The service had a surgery mandatory training action plan (2019) which was being monitored through the divisional board, departmental meetings and accountability review meetings. The aim of the action plan was to have all statutory and mandatory training completed by the end of September 2019. We saw outcomes which included the theatre manager discussing with the training team the possibility of bespoke training on audit half days and arranging additional support to specific staff groups. (Source: DR110)

Records seen identified that recovery staff were trained in immediate life support (ILS) as well as paediatric immediate life support (PILS) which meant they had the competency to attend to patients at risk of, for example, a cardiac arrest. At our previous inspection in March 2018, we highlighted that not all theatre recovery staff had advanced life support (ALS) 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). The Royal College of Anaesthetists (RCoA, Guidelines for the Provision of Anaesthesia Services, 2019) recommends that all staff should be trained to immediate life support level and at all times there should be immediate access to a member of staff trained in ALS or an anaesthetist. Theatre recovery staff did not all hold ALS training, however senior staff informed us that theatre staff were not required to lead on cardiac or respiratory arrests within theatres as this was led by the anaesthetist and supported by the resuscitation team. The trust informed us that they recognised that this may constitute a risk, and this had been added to the risk register (risk 6147) with a view to increasing training to meet best practice guidance.
Not all clinical staff had completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, during the inspection staff were able to express how they would recognise and respond to patients with complex needs. Records seen showed that documentation was completed in line with trust policy and guidance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Line managers had access to up-to-date training data, which showed mandatory training compliance for their staff. Managers informed us they reviewed and booked staff onto their training as required.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all medical staff had completed their training on how to recognise and report abuse although they knew how to apply it.

Safeguarding training completion rates

Trust level

Nursing staff received training specific for their role on how to recognise and report abuse.

The trust set a target of 90% for completion of safeguarding training. The 90% target was met for all four safeguarding training modules for which registered nurses in surgery at trust level were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for registered nurses in surgery at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>317</td>
<td>347</td>
<td>91.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>315</td>
<td>346</td>
<td>91.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>313</td>
<td>346</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>313</td>
<td>347</td>
<td>90.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Medical staff had not received training specific for their role on how to recognise and report abuse. The service had a safeguarding training action plan (2019) which was being monitored through the divisional board, departmental meetings and accountability review meetings. The aim of the action plan was to have all training completed by the end of August 2019. (Source: DR111).

Senior staff informed us that no level 3 safeguarding training was required within the surgical division. This was because children's nurses who had the appropriate level of training accompanied children and young people at all times in theatres and recovery (please see core service report for children and young people’s services).

Senior staff informed us that there was a lead anaesthetist with level 3 compliance in safeguarding, but this member of staff was not always present in theatres when a young person was in the operating theatre or recovery.
The 90% target was not met for any of the four safeguarding training modules for which medical staff in surgery at trust level were eligible. A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in surgery at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>225</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>229</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>214</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>220</td>
</tr>
</tbody>
</table>

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. We saw these had been reviewed and were up to date. Nursing staff showed us how they would locate them on the trust's intranet system. We saw examples within patient records of staff using the correct documentation to protect patients.

Prevent is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being radicalised into supporting terrorism or being terrorists themselves. We saw that Prevent awareness training across the trust was at 91% and 87% for workshop to raise awareness of prevent (WRAP) training. During the inspection nursing staff explained how they protected patients and the processes to follow should they have any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All wards we visited had a safeguarding folder with up to date information, including contact details and how to make referrals. The surgical division made 14 referrals to the safeguarding team from April 2018 to March 2019. A serious case review (SCR) or safeguarding adults review (SAR) took place after a child or vulnerable adult died or was seriously injured and abuse or neglect was thought to be involved. They also took place in cases of homicide or criminal activity involving children or adults. The reviews looked at lessons that could help prevent similar incidents from happening in the future. There had been none reported for the surgical service during this time. However, staff we spoke with knew the process to follow which meant that they had the necessary knowledge when involved in a SCR or SAR.

Staff followed safe procedures for children visiting the wards. During our unannounced visit on 5 August we observed children visiting. Staff on ward 7BN said that children under two years old were not allowed to visit the ward to reduce the risk of infection to both the child and patient and all children were to be supervised by the accompanying adult which was in line with trust policy. Staff confirmed they had not had any issues or concerns regarding children visiting and this was encouraged where possible to support their relative’s recovery.

Cleanliness, infection control and hygiene
The service did not always manage controlled infection risks well. Staff did not continually use infection and control measures to protect patients, themselves and others from infection. However, the service used systems to identify and prevent surgical site infections. The services equipment and premises were visibly clean.

Staff did not always follow infection control principles including the use of appropriate personal protective equipment (PPE) or follow hand hygiene practices. Personal protective equipment, such as gloves and aprons were available in enough quantities on all wards.

We saw a letter from NHS England (NHSE) and NHS Improvement (NHSI) (June 2019) which stated that the trust had demonstrated a sustained improvement in infection prevention and control standards with the trust being assessed as NHSI infection prevention level green. However, during the inspection, we observed inconsistencies with staff compliance with the trust’s infection prevention and control (IPC) policy. This was also identified as a concern in the previous inspection of March 2018. This was brought to the attention of the matron, manager and nurse in charge during our visit. For example;

- On ward 5A, 5B, 7BN, 7BS and Swift ward we saw visiting doctors did not always wash or sanitise their hands following patient contact.
- Staff on ward 5A, 5B, 7BN, 7BS and 8A did not always follow hand hygiene protocols after multiple patient care tasks.
- We observed staff on 5B handling and moving equipment which had been on the floor without the use of gloves or apron.
- We observed a doctor wearing a wristwatch on ward 7BS.

The inspection report for March 2018 identified that the phlebotomists on the surgical wards did not always wear gloves when taking blood. During this inspection, while on ward 8A we observed phlebotomy staff not consistently wearing gloves when taking blood and moving between patients. 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 doctor on ward 7BS wore a wristwatch and was not challenged to observe trust protocol. We also observed a doctor visiting ward 5A wearing a jacket. They did however, take this off prior to seeing their patients. Staff we spoke with said they did not always feel comfortable in challenging the doctors to be compliant with being arms “bare below the elbow” and left this to senior staff to deal with.

In February 2019 the infection protection and control (IPC) team and senior staff undertook a new hand hygiene competency and training. The overall figure for the surgical division was 87% as at June 2019. This continued to be below the trust target of 95%. We saw the nursing and quality indicator for June 2019 which provided a breakdown of surgical wards. None of the wards achieved the trust compliance of 95% except for ward 8B which achieved 100%. For example, the wards achieved the following: ward 5B (83%), ward 7B (88%) and ward 11B (67%). It was noted that no data was provided from Swift ward, 5A and 8A wards. (Source: DR129 Nursing and midwifery quality indicators June 2019). Following the inspection, the trust provided us with updated compliance figures for the WHO checklist. The aim was to increase compliance for WHO Moment 1 to 90% and WHO Moment 2–5 to 80% by June 2019 from a 55% baseline in July 2018. The figures provided by the trust showed both Moment 1 and Moments 2-5 at 86%. (Evidence: IPC report June 2019 - appendix 5)

All ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw equipment with dated “I am clean” stickers which enabled staff to instantly recognise when equipment was last cleaned.
The service score for cleanliness was better than the England average. We saw the Patient-Led Assessments of the Care Environment (PLACE) audit for 2018 which showed the trust had scored 99% for cleanliness which was like the national average. In addition, weekly peer audits and/or weekly matron audits of clinical areas were undertaken. Both results fed into the trust’s business intelligence tool and the results were sent out monthly to the individual areas. We saw the June 2019 cleanliness audit which showed the following results: Ward 11B (100%), Wards 8A and 8B (94%) and Ward 7B (94%). (Source: DR101).

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed housekeeping staff completing various tasks throughout the course of the inspection. Patients told us they were happy with the cleanliness of the wards and public areas.

Staff cleaned equipment after patient contact to show when it was last cleaned. We saw nursing staff on ward 5B being allocated cleaning duties for the day which included for example; the cleaning of commodes. This meant staff accountable for the cleanliness of equipment were identifiable should any concerns arise. Current data seen showed 86% compliance as at May 2019 which was below the trust target of 100% but had improved from 55% compliance in October 2018. (Source: Appendix 5 – IPC report June 2019)

Staff generally worked effectively to prevent, identify and treat surgical site infections. All infections were reviewed by the director of IPC supported by the IPC team to ensure learning was implemented. We saw that six surgical site infection cases were attributed to the surgical service from August 2018 to February 2019. (Source P67/82).

The national target for MRSA bacteraemia (blood steam infections) was zero and the infection prevention and control report (May 2019) reported no attributed case for the surgical division. The quality and safety dashboard for June 2019 showed 85% compliance for MRSA screening across the surgical division which was just below the trust threshold of 90%.

There had been two cases reported for the surgical division of hospital acquired C. Difficile for June 2019. (Source: Surgery division accountability review meeting (ARM) report June 2019). The service took the following actions to improve this score and the quality of its services by:

- auditing infection prevention and control practices
- delivering the infection control improvement plan
- undertaking post infection reviews to identify gaps in care and potential learning.

The surgery divisions’ accountability review meeting (ARM) report for June 2019 identified one hospital acquired MSSA (methicillin sensitive staphylococcus aureus) incident.

E. coli bacteria is frequently found in the intestines of humans and animals and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract and intestinal infections. There had been a total of 13 cases of E. coli bacteria attributed to the surgical service from April 2018 to March 2019 and a further five for April and May 2019. (Source: Appendix 5 – IPC report June 2019). All cases were reviewed by the IPC team.

The service collected data for all total hip and knee replacements and fractured neck of femurs. From April to June 2018, the surgical site infection (SSI) rate for total knee replacement increased to 3.1% (benchmark 0.5%) and the trust had been identified as a high outlier. (Source: P67).
Surgical site infection October 2014 to June 2018

(Evidence source: Appendix 5 – IPC report June 2019)

Actions taken included reviewing cases to identify learning, re-auditing of the theatre environment and individual feedback to surgeons. Senior staff informed us that infection rates for total hip replacement and repair fractured neck of femur currently remained near or below the national benchmarks. This data was shared at the trust infection prevention and control committee and the surgical site infection (SSI) multidisciplinary working group.

Laying-up of sterile instruments in the operating theatre is an important quality process and should keep instruments sterile to be used for the procedure. During the inspection we found theatre staff were laying up surgical trolleys in advance of the procedure which meant there was a risk of instruments not remaining sterile. This was brought to the attention of senior staff. Following our feedback, the service took immediate action to address this. A memorandum was sent out to all theatre team managers which stated that all instrument trolleys, must not be laid up in procedural areas for more than one patient at a time. The trust informed us the concern was due to be raised as part of the next clinical governance audit afternoon and at the next cross-site theatre staff meeting on 20 August 2019. Random daily sample audits had commenced from 1 August to improve practices in response to the concerns raised. Theatre trolley “lay-up” audits seen for August 2019 showed weekly improvements with this process.

The surgical service had systems in place to ensure that water sampling was completed regularly. A water safety plan was in place which was overseen by the water safety group to ensure threats posed by for example legionella (a bacterium that could cause a pneumonia-type or flu like illness) and pseudomonas aeruginosa (a bacterium that can cause a ventilator-associated pneumonia and various sepsis syndromes) were identified and dealt with. There had been two water related infections reported for the year April 2018 to March 2019. We saw there had been one case of pseudomonas reported for May 2019. There were no issues or concerns identified during the inspection.

Environment and equipment

The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always carry out daily safety checks of specialist equipment. However, staff were trained to use them. Staff managed clinical waste well.

We highlighted concerns with the availability of emergency call bells on surgical wards in the inspection report for March 2018. During this inspection we found that this concern remained the same on wards 5A, 5B, 7A, 8A and 11B. Staff said if they needed help, they would shout. An emergency call button is usually found behind the patients’ beds for staff to alert other nursing
practitioners that help is required quickly, for example if a patient should collapse. While the trust had a risk assessment in place for the emergency call bell system most staff spoken with were unaware of the risk assessment to mitigate the risk. There had not been any reported incidents due to the lack of an emergency call bell nor was there any identified serious incidents. The emergency call bells were monitored by the serious incident review group and deteriorating patient working group and no concerns had been highlighted in any post-arrest review.

The March 2018 inspection highlighted ward areas having allocated storage cupboards in the main corridors with the doors being kept open. The stored items included needles, syringes, and bottles used for blood tests. During this inspection, while visiting ward 7B we found the storage cupboards continued to be unlocked which meant that clinical equipment was accessible to anyone who had been in the corridor. We also found out of date equipment within the storage cupboards which included two face masks. This was brought to the attention of senior staff who immediately disposed of the equipment. The trust informed us that because of our findings they had reviewed all clinical areas and that the matron audit programme would continue to monitor this.

While visiting the theatre area we found a clean store which was dirty, with boxes stored on the floor reducing access for cleaning. This was brought to the attention of senior staff. Following the inspection, for ease of cleaning in the theatre areas, trolleys on wheels had been ordered and implemented and were in use which ensured that boxes were not left on the floor. Staff were reorganising the storage area to make the area more functional and clutter-free. Laminated signs had been put in place to clearly identify where equipment could be safety stored. Senior staff informed us they had completed random audits to confirm this was in place.

Staff did not always carry out daily safety checks of specialist equipment. The inspection of March 2018 found that ward staff did not complete a bed space checklist to include checks of gas/tubing connection. This was implemented after a never event that occurred in March 2018. We saw the checklist which clearly states that: “the checklist must be completed by a member of the nursing team within 30 minutes of admitting a new patient to the bed space, as evidence that the bed space remains clean and tidy and that oxygen and suction tubing are present.” During this inspection we only found one completed checklist from 17 records reviewed. This meant that we could not be sure that there were processes and procedures in place to oversee the completion of the checklist to maintain the safety of patients or lessons learnt from a never event.

Gaps were identified in the checklist of the anaesthetic machines. This was not in line with the Association of Anaesthetists for Great Britain and Ireland (AAGBI) guidance which requires that the anaesthetic machine is checked and tested daily prior to the start of the operating list. As soon as checks are completed, the log book must be dated and signed. The log books seen identified gaps with no date or signature available. For example, we saw the following gaps in theatre two: May (07) June (12), July (1, 3, 4), theatre eight: May (06, 08, 09, 13, 17), June (03, 24), July (01, 19) and in theatre nine June (03, 04, 06, 07, 10, 17, 18, 20, 25) and July (09, 10). We also noted that this had not been completed during our visit to the theatres on 23 July. We saw the clinical commission group (CCG) theatre report for March 2019 which identified that daily checks had not been signed for on the anaesthetic machine and it was noted that there were gaps across the anaesthetic rooms. *(Source DR108).* This was brought to the attention of the senior management team. Following the inspection, a memorandum was sent to all staff reinforcing the policy for documenting the checking of this equipment. A random audit of 35 checks was completed over five different dates following the inspection. We saw the anaesthetic equipment checklist audit for April, May and June 2019 based on seven random machines on five different dates. *(Source DR120)* We saw that gaps had been identified on five occasions in April; four in May and three in
June showing an improvement each month. The audits stated that action had been taken, but this was not documented which meant that we could not be assured what processes were in place to manage the gaps to ensure that the equipment was safe for use. After our inspection, the trust told us that the random daily audit would be continued until there were assurances that the checklists were being consistently completed and the process was embedded. We were also told that this issue would feature in trust wide learning to encourage consistency and embedding fundamental safety practices.

The service did not have equipment for monitoring end tidal carbon dioxide (EtCo2) and capnography. The aim of EtCo2 is to monitor ventilation by tracking respiratory rates as well as breath-by-breath trend of carbon dioxide as it is eliminated from the lungs. Capnography is the monitoring of the concentration or partial pressure of carbon dioxide in the respiratory gases. The trust informed us that theatres do not currently routinely monitor capnography and ETCo2 in recovery. This was reflected in the local theatre policy; recovery care guidelines and intensive treatment unit/ventilated patients which states: ‘pulse oximeter, blood pressure, temperature and electrocardiography (ECG) should be available for all patients.’ Staff informed us that patients that were intubated were connected to an anaesthetic machine and an anaesthetist must remain with the patient. We were informed that a full review of monitoring had taken place within theatres and critical care and a business case was being written, which supported the request for capnography/EtCo2 monitoring to be available within the recovery areas. This was in line with the AAGBI guidance “Immediate Post anaesthesia Recovery 2013 (21)” which states that “monitoring must continue until the patient has recovered from anaesthesia. Anaesthesia departments must work towards providing capnography monitoring throughout the whole period of anaesthesia from induction to full recovery of consciousness.” We did not see any patient requiring the use of either EtCo2 or capnography during the inspection. (Source: DR130)

Equipment reviewed on the wards showed evidence of electrical safety checks and required maintenance. There was a paediatric resuscitation trolley for use in the recovery room which staff checked regularly. Equipment and supplies in the trolleys we examined were fit for purpose and within use by dates. However, we found a resuscitation trolley within the theatre which had not been checked daily. This was brought to the attention of the senior managers. Following the inspection, the trust re-iterated the importance of daily checking through the ‘Friday at eight’ communication forum and staff safety huddles. To ensure continued compliance this was being monitored through the theatre quality improvement plan, matron’s quality audits and peer compliance audits. Data provided showed the surgical division resus checking results averaging 97% as of August 2019.

Staff confirmed they had enough sterile packs and instrumentation to meet their needs. When additional instruments or packs were required staff said they received them promptly and there were no issues with availability.

The design of the environment followed national guidance. We observed the layout and design of the surgical services had been considered to ensure that the environment was suitable to making patients feel at ease and give them confidence. For example, we visited the pre-operative assessment area and found the atmosphere to be airy and calm with natural lighting.

The service had suitable facilities to meet the needs of patients’ families. Staff on the wards that we visited said they aimed to provide a patient-centred system which considered the patients’ individual needs. For example; staff on ward 5B said that they often accommodated families to stay overnight when necessary. Staff said this helped patients to focus on their health and well-being and supported early discharge.
The service had enough suitable equipment to help them to safely care for patients. The medical equipment maintenance assurance framework was monitored via the trust’s medical devices committee. The facilities department worked with the clinical users to obtain access and ensure that the medical equipment was maintained. There were planned preventative maintenance schedules for servicing equipment within the clinical areas across the service. The purchasing of new/replacement standardised models of medical equipment was undertaken through the procurement team. Senior staff said they were considering a replacement programme for the surgical service, this was currently work in progress.

Concern had been raised relating to anaesthetic machines with 11 machines identified as being potentially unsafe to use after December 2020 when oxygen sensors for the machines would cease to be produced. This would leave the machines unable to measure inspiratory/expiratory oxygen concentration in anaesthesia. Senior staff informed us that they had been allocated a sum of money for the procurement of new machines, but this had recently been reduced and consideration was being given to leasing equipment rather than purchasing. We noted this had been included on the trust’s risk register.

Products were not always stored safely. For example, on ward 7A we saw products deemed as hazardous to health such as cleaning solutions being stored in an unlocked cupboard within the dirty utility room. The entry door was also open even though it had a key pad entry system to ensure it was kept locked. This was brought to the attention of senior staff who immediately rectified these matters.

The airflow systems in the operating theatres were validated and checked against standards set out in national guidance Health Technical Memorandum (THM) 03-01; “Specialised ventilation for Healthcare Premises” 2007. The trust had arrangements for the maintenance of medical devices in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices (April 2005), and other national guidance. For example, we saw copies of the air quality monitoring report for the treatment centre (theatres 5 and 6) with no issues or concerns identified.

We saw that the theatre environment was included in the improvement plan for surgical site infections July 2019. Areas covered included:

- ensure compliance to include ventilation and fabric (Progress – in progress not complete).
- laminar flow contract in place to ensure maintenance and timely response to issues when identified (Progress - procurement tender being drafted). (Source: DR102).

Staff on ward 5B informed us that they had to borrow electrocardiograph (ECG) machines and bladder scanners as theirs were broken or being repaired. Equipment was not tracked, meaning that staff did not know where the pieces of equipment were. A book to record their whereabouts of equipment had been started on the ward, but we noted that this had not been maintained.

During our inspection, we did not see any bariatric equipment in the ward areas. Staff told us some bariatric equipment was available to borrow from other wards, or the equipment store when required.

Not all ward areas had a controlled intercom device for example, 7B, 8A and 11B. This meant there was a risk of unauthorised access to those areas and of confused patients being able to leave the ward unsupervised. During the inspection, we observed a patient living with dementia walking with purpose along the corridor when they should have been receiving one-to-one support. The patient was escorted back to the ward and senior staff informed of their location. We saw staff dealt with our concerns to ensure that patients who required one-to-one care were adequately supported.
Staff disposed of clinical waste safely. We saw guidance was available for the segregation, storage and the transportation and disposal of clinical waste. The signage explained which colour bag to use for specific clinical waste.

Sharps bins were readily accessible with lids temporarily closed for safety with no issues or concerns identified.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. For example, the service followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines and we saw evidence of staff across the wards and theatre recovery area using the national early warning scores (NEWS2). Not all theatre staff were compliant with NEWS2 training. This applied to all theatre practitioners and care support workers. The goal was for theatres to be 90% compliant by the end of September 2019. We checked the observation charts of 17 patients and found the NEWS2 score had been recorded and escalated appropriately.

Pre-operative assessment nurses had a clear criterion to follow with patients being referred for an anaesthetic review when required. This was in line with the National Institute for Health and Clinical Excellence (NICE) guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016) and guidance from the Modernisation Agency. They reviewed the results of all investigations and flagged abnormal results to the anaesthetist assigned to the operating list, if known, or to the anaesthetic pre-assessment worklist. We observed that all haematology (a branch of medicine involving the study and treatment of the blood) results within the pre-operative assessment clinics were on paper which staff confirmed was very time consuming. We discussed the risk of missing the result/outcome of a blood test with staff and the risk of transposing the data onto the trust’s electronic system. They confirmed there was the potential of a risk with results being either missed or mis-read. We reviewed the incident reports and found no issues or concerns regarding haematology. However, we noted this was identified as a risk within the service.

To reduce and potentially eliminate errors occurring in the operating theatre, the trust used the World Health Organisation (WHO) surgical safety checklist which was in line with National Patient Safety Agency (NPSA) guidelines. The service used the five steps to safer surgery. Step one was the team briefing or “huddle” where the team went through the list order to identify any concerns prior to the surgery. The WHO form accounted for steps two to four and was completed for each patient while step five was the team debrief at the end of the list.

The trust informed us that they were undertaking both quantitative and qualitative audits of the WHO checklist throughout the theatre areas. The quantitative audit was completed on a random sample of 10% of all WHO forms collected across all locations and specialities. The qualitative audits were two-fold which included an audit of the team brief/de-brief and an observational audit.

We saw the WHO checklist audits for May 2019 which are set out below.

May 2019 WHO audit checklist
During the inspection, we observed inconsistencies in the completion of the WHO checklist. For example, we saw staff discussing a different patient to that identified on the white board prior to a procedure. Although this was brought to the attention of staff, we observed that they continued to complete the checklist using the wrong patient information. This meant that we could not be assured that staff were responsive to information provided to manage the checklist appropriately.

Following the inspection, the trust has reviewed, redesigned and standardised the whiteboards in theatres and ordered new boards that would be on site the end of September 2019. They informed us they had implemented daily audits and oversight to ensure compliance until the new boards were in place.

The clinical commission group (CCG) theatre report for March 2019 stated that staff advised that if the WHO checklist was not completed in its entirety this was recorded retrospectively on the form and included as compliant. The CCG report identified that this audit process was inconsistent across the division. One member of staff stated that the record being returned for completion would not be documented as it being finished retrospectively. During the inspection we looked at four WHO checklists, there were no issues or concerns identified. However, recovery staff confirmed they sent the WHO checklist back to theatre for completion but did not sign the form as
having been completed retrospectively. This meant that we could not be assured that the audit was an accurate and true reflection of the completion of the checklist.

If a patient deteriorated during a local anaesthetic minor operation staff said that they would call for help from the nursing staff on the nearby ward where the resuscitation equipment was located. Staff confirmed they started basic life support while awaiting the arrival of the resuscitation team. Oxygen and suction were available in the clinic room. Following minor operative procedures, patients retired to an area in the main ward corridor area for recovery pending discharge. We observed that this area did not have constant nursing supervision or regular checks. Staff said this was standard procedure and if patients felt unwell, they alerted a member of staff and were taken into a dressing clinic area until they felt better.

Staff knew about and dealt with most specific risks. Risk assessments were carried out on patients when they were admitted to the surgical service. This included risk assessments for falls, malnutrition, and pressure ulcers. These were documented in the patients' records and included actions to mitigate any identified risks. These assessments should have been updated regularly; we saw that from the 17 records seen, this did not always happen.

The National Institute for Health and Care Excellence (NICE) guidance (NG89) for March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding, as soon as possible after admission to hospital, or by the time of the first consultant review. Reassessments for VTE should be at the point of consultant review or if their clinical condition changes. The inspection of March 2018 identified concerns with the completion of a VTE reassessment within 24 hours of admission. During this inspection, we found no issues or concerns with the recording of VTE reassessments.

The trust audited the percentage of patients having a VTE assessment and reported on these. The data seen for the surgical division showed 93% compliance as of May 2019 which was just below the trust threshold of 95%. (Source: DR104). The trust had implemented the following actions to improve this score, and the quality of its services by:

- monitoring the routine processes around data gathering
- undertaking additional spot-check audits
- evaluating incidents where a hospital acquired thrombosis has occurred to generate learning and change practice.

All elective patients completed a preoperative questionnaire. The questionnaire was reviewed with a trained pre-assessment nurse and any concerns were identified and discussed with an anaesthetist. If necessary, the patient would be referred to the high-risk anaesthetic clinic where an assessment would be made to assess what investigations/input were needed from relevant teams such as cardiology or respiratory. There was a separate process for patients undergoing ear, nose and throat procedures, who were overseen by a clinical nurse specialist.

All emergency patients were assessed by the surgery and anaesthetic team and any essential investigations requested and expedited if necessary. There were policies regarding the management of diabetic patients, medicine management and those patients who were on blood thinning medicines.

We checked the sterile surgical instrumentation checklist. We saw that a line was drawn vertically to indicate all instruments were present and correct. However, the form did not have the name of the checker and theatre details which was not in line with good practice. This was brought to the attention of staff during the inspection. Following the inspection, the trust informed us that they have included the form on their audit checklist, because of our findings during the inspection.
The level of patient falls was monitored by the service. We saw the falls audit documented in the accountability review meeting (ARM) report for June 2019 which totalled 19 for the surgical division. The falls audit scored from 78% (7B ward) to 91% for wards 8B, 11B and 5B. All the falls were classified as either none or low harm. The identified area for improvement included the need to understand clusters and themes. Staff we spoke with understood the need to identify when falls occurred but were not aware of any identified themes or concerns.

Staff we spoke with informed us they used the Baywatch scheme to ensure the safety of patients. The aim of Baywatch was to prevent falls during the day and night by allocating a member of staff within the bay to enable to enable maximum observation of patients. Senior staff we spoke with said they were looking at staff having identifiable lanyard to support the scheme

During 2018/2019 the trust declared a total of 101 pressure ulcers including three grade 4 pressure ulcers. Data was also gathered on ulcers resulting from device use, such as naso-gastric tubes (a tube passed through the nose, past the throat and down into the stomach), and deep tissue injuries. The surgery division ARM report for June 2019 identified 10 hospital acquired pressure ulcers. Staff spoken with said they had processes in place to manage pressure ulcers appropriately. For example, we saw that ward 11B had gone over nine months without an acquired pressure ulcer. (source: DR129)

Patients identified as being at risk of pressure ulcers were provided with alternative pressure relieving mattresses which was in line with the Royal College of Nursing Management of Pressure Ulcer guidance. Nursing staff reported having access to specialist equipment to meet individual patient needs when required.

Staff confirmed they had access to the tissue viability team (TVT) which adopted an integrated approach to wound care management. All incidences of hospital acquired pressure ulcers were subject to a root cause analysis (RCA) with learning being shared at daily huddles and team meetings.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). 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 completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The hospital had an alert system for patients identified or thought to be at risk or having the following symptoms; self-harm, suicide, dementia, learning disability, deafness or severe blindness. Records seen showed that patients had been appropriately assessed using several tools to identify needs, unmet needs and mental capacity.

Staff shared key information to keep patients safe when handing over their care to others. The handover between theatre and recovery staff followed a prescribed situation, background, assessment and recommendation (SBAR) style template and was documented. The SBAR technique promotes and facilitates prompt and appropriate communication between professionals. Staff confirmed that handovers were consistent and useful.

Shift changes and handovers included all necessary key information to keep patients safe. We attended a shift handover and found this to be effective. Each patient was discussed which provided staff with an up to date overview of the treatment required. The handover also included patients with for example; pressure ulcers, safeguarding concerns, time critical medicines and patients deemed to be at high risk of falls. This ensured staff were continually updated on the plan of care for every patient on the ward and the nurse in charge maintained an effective oversight of the patients in their care.
Safety huddles occurred daily after the handover. These huddles described key matters of concern such as staffing levels or demands on the service. Nursing staff on the wards told us they had a minimum of two daily safety huddles. We observed the safety huddle on ward 5B. Each ward recorded the meeting in a log book.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep patients safe. Senior staff informed us that staff retention was good and that agency staff were not used but there was reliance on the good will of the nurses to do bank shifts. Registered staff to patient ratio was shown on the roster dashboard. The trust adhered to national recommendations and had an average staff to patient ratio in surgery of 1:7 (Source: P71). Three daily staffing meetings and weekly look ahead meetings supported the service in balancing staffing risks across the trust. These meetings fed into the operations centre to ensure that risk was being maintained throughout the day and night.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and care support workers needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. There were systems and processes in place to assess, plan and review staffing levels, including staff skill mix. Senior staff used the national safer nursing tool to assess, identify and plan staffing levels. The safer nursing care tool is an evidence-based tool developed to help hospitals measure patient acuity and dependency and determine workforce levels. The matrons reviewed these to ensure staffing risks were addressed and any safety issues that arose were managed. This process was in line with the National Institute for Health and Care Excellence (NICE) in relation to its guidelines for Safe Staffing (SG1). This tool also worked out the utilisation of the wards daily. We observed there was a clear escalation process established within the division. This meant that senior managers could see gaps in staffing levels and act upon this appropriately. Staffing levels were appropriate to meet patients’ needs during our inspection.

The number of nurses and care support workers on all shifts on each ward matched the planned numbers.

The safer staffing report for February 2019 identified the following wards as falling below the agreed levels. Shifts that fell below minimum staffing levels were escalated to the divisional staffing bleep holder (a senior nurse) who moved staff to balance risk across the division. For the surgical service these were:

**Surgical nursing shifts**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Early</th>
<th>Late</th>
<th>Night</th>
<th>Number of shifts where staffing initially fell below agreed levels</th>
<th>% of shifts where staffing fell below agreed levels and triggered a Red rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>5B</td>
<td>14</td>
<td>15</td>
<td>3</td>
<td>32</td>
<td>38%</td>
</tr>
<tr>
<td>5A</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td>25</td>
<td>30%</td>
</tr>
<tr>
<td>7B</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>14</td>
<td>17%</td>
</tr>
<tr>
<td>8A</td>
<td>8</td>
<td>12</td>
<td>5</td>
<td>25</td>
<td>30%</td>
</tr>
<tr>
<td>8B</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>18</td>
<td>21%</td>
</tr>
<tr>
<td>SAU</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>5%</td>
</tr>
</tbody>
</table>
We looked at staffing rotas during the inspection. For example, we saw that Swift ward had 18 unfilled shifts for June 2019 and up to 24 July there had been 21 unfilled shifts. Despite these unfilled shifts, staff said they were happy with the staffing levels on the ward and patients said they felt there were enough staff to meet their needs. While on the surgical assessment unit the rota for July 2019 showed nine half shifts were unfilled. The ward manager advised that these shifts may have been covered by rapid response, but these would not show up on the system. This meant that it we could not evidence whether the shifts had been filled or not.

**Trust level**

The table below shows a summary of the nurse staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,074</td>
<td>8%</td>
<td>14%</td>
<td>4.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>377</td>
<td>9%</td>
<td>15%</td>
<td>5.1%</td>
<td>74,264</td>
<td>28,982</td>
<td>18,863</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within surgery at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness and bank use.

**Sickness rates**

Each ward had sickness rates at or below the trust target. The surgery ARM report for June 2019 showed that short term sickness had decreased to 1.76% and 1.75% in May and June 2019 across the service. Long term sickness had stayed low with a small rise to 1.9% from 1.54% in June 2019. The overall sickness for June 2019 was stabile with a small rise from 3.31% to 3.67%. We saw the actions which included conversations within the divisional leads and sickness clinics being conducted.
Vacancy rates

The service had low and reducing vacancy rates.

![Vacancy rate chart]

Monthly vacancy rates over the last 12 months for registered nurses, health visitors and midwives in surgery at trust level showed a shift from October 2018 to March 2019. Senior staff and nurses on charge of wards said that their vacancy rates had decreased with most wards having a full complement of staff. Some wards said they were waiting for staff to commence their employment and were currently using bank staff to maintain continuity. Staff said they had participated in the recruitment process which they felt was “good” and “worked well.”

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

Turnover rates

Each ward had turnover rates at or below the trust target.

![Turnover rate chart]

Monthly turnover rates over the last 12 months for registered nurses, health visitors and midwives in surgery at trust level, showed an upward trend from August 2018 to December 2018.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Agency staff usage

Agency hours over the last 12 months for registered nurses and midwives in surgery at trust level showed a shift from October 2018 to March 2019. Senior staff informed us they used bank staff to maintain staffing levels. They confirmed they were waiting for new staff to commence employment which would improve the trend of using agency or bank staff.

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

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Trust level

The service did not have enough medical staff to keep patients safe.

The table below shows a summary of the medical staffing metrics in surgery at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1,074</td>
<td>8%</td>
<td>14%</td>
<td>4.7%</td>
<td>23,785</td>
<td>11,875</td>
<td>2,876</td>
</tr>
<tr>
<td>Medical staff</td>
<td>289</td>
<td>5%</td>
<td>8%</td>
<td>1.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
The trust was unable to provide the total available hours in their bank and agency data. For this reason, we have not calculated bank and agency usage as a percentage of available hours.

Medical staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank or locum use.

The medical staff matched the planned number on all shifts in each department.

Gaps to the rota of doctors and dentists in training were monitored monthly. This review allowed for identification of clinical teams that were short of staff. The table below shows the average number of rota gaps in each of the quarters.

<table>
<thead>
<tr>
<th>April to June 2018</th>
<th>July to September 2018</th>
<th>October to December 2018</th>
<th>January to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>35</td>
<td>38</td>
<td>36</td>
</tr>
</tbody>
</table>

(Evidence Source: P82 Quality and safety report April 2019)

The gaps were being filled by temporary staff and regular staff well known to the organisation. Recruitment initiatives to fill these posts continued. For example, the trust was liaising with the East of England deanery to maximise the number of junior doctor posts assigned.

Concerns with junior doctor rotas/contracts were also highlighted in the audit committee meeting minutes for January 2019 with rota gaps continuing to cause problems. Gaps from vacancies and failure to cover for rota gaps due to illness had resulted in a high number of reports from surgical rotas, most of which cited a lack of support in their day to day work. The surgical team had reported four safety reports although none related to working unsafe hours. It was advised that the lack of shifts being filled was due to the agency spend. All shifts were reviewed daily with a status around safety. We saw the actions relating to this concern which included:

- a request for further assurance on the high level of unfilled shifts.
- a request for further assurance of the qualitative difference between the figures for the months reported.

**Staffing skill mix**

In February 2019, 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.

**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>39%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>29%</td>
<td>29%</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)

The service had high vacancy rates for medical staff. During the inspection we discussed the shortage of staff and the rota gaps. Senior staff confirmed there were ten anaesthetists and two consultants short. They confirmed they were actively recruiting. Medical staff we spoke with confirmed that the shortage of medical staffing was having an impact on the service and their ability to take up extra shifts resulting in additional theatre lists not being implemented. They confirmed they were beginning to feel “burnt out” and were not taking up any additional activities.

The service had low turnover rates for medical staff.

The service used a high rate of bank and locum staff on the wards. Managers could access locums when they needed additional medical staff. Managers confirmed that the locums they had on their wards were permanent staff which provided continuity to both patients and staff.

Managers made sure locums had a full induction to the service before they started work. Locum staff confirmed they had received a full induction and said the training provided was very good and supported them in their role.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Senior staff confirmed they reviewed the medical staff on each shift to ensure there was both enough staff and that the skill was appropriate to the area worked. Junior staff we spoke with confirmed they were very happy with the rotation of training and skills they received and had access to consultant for support when required.

The service always had a consultant on call during evenings and weekends. Managers and nursing staff confirmed that consultants were easily accessible and did not have any issues or concerns.

Records

Staff did not always keep detailed records of patients’ care and treatment. Records were not stored securely. Records were not always clear and up-to-date. Registered nurses had not completed the enhanced care bundle in line with trust guidance. However, records were easily available to all staff providing care.

Records were not stored securely. The inspection of March 2018 identified that not all records were stored securely. During this inspection we also found that medical records were not stored securely. Medical records should be stored in locked cupboards to ensure that unauthorised individuals cannot access confidential information. Although the wards visited had the facility of a key pad locked trolley, we found medical records left unattended on reception tops. This was found on wards 5A, 7BN, 7BS and 8A.

Patients and visitors could access 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 and medical reviews which had been carried out during the admission.

Patient notes were not always comprehensive. We reviewed 17 sets of nursing and medical records and found these mostly to be in good order. All entries were dated, signed and included the clinician’s bleep number when appropriate. The hospital used a paper-based record system
which included two sets of records: a nursing risk assessment and care plan folder and a medical notes folder. The records seen included risk assessments and care plans. Nursing care plans were standardised, and patient records also identified the input from the multidisciplinary team, such as therapists and dietitians. However, the records did not identify the patient’s involvement in their care plan to ensure they received the care that was appropriate to them.

Bedside records were not always updated by nursing staff and care support workers. 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. We found that some fluid balance sheets were partially completed and did not have their totals calculated. The anaesthetic documentation audit from April 2018 to May 2019 scored 82% based on 65 records while the surgical inpatient documentation audit (April 2018 to June 2019) scored 81% based on 87 records. For example, we saw 51% compliance for all relevant information being recorded (including fluid totals) and 84% for the NEWS score being completed during this episode.

The enhanced care bundle which was completed daily included an oversight of the patient’s care management. The care bundle clearly stated that this was to be signed daily by the registered nurse. We found that only a few had been reviewed and signed by nursing staff. This meant that staff were not following the processes in place to ensure they had oversight of the patients’ individual needs.

When patients transferred to a new team, there were no delays in staff accessing their records. There were processes in place when patients moved between teams, services and organisations which included referral, discharge, transfer and transition. We saw all the information needed for their on-going care was shared appropriately.

**Medicines**

The service did not use systems and processes to safely prescribe, administer and record medicines. Staff did not always escalate the recorded temperature of stored medicines to maintain their safety.

Staff did not store and manage all medicines and prescribing documents in line with the provider’s policy. Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. However, we observed that medicine records were not stored within patient records but left out on the surface next to the medicine storage cupboards. This meant there was the risk of medication administration records (MAR) going missing and being seen by unauthorised personnel.

During our inspection, we observed staff following the safe administering of medicines in accordance with guidance from the Nursing and Midwifery Council. We observed two nurses checking controlled drugs according to trust policy which included checking the medicines against the prescription chart and correctly identifying the patient. We observed staff asking patients if they had any known allergies. This was in line with maintaining and sharing drug allergy information as recognised by NICE clinical guideline 183 (2014).

The inspection of March 2018 identified concerns with staff not following the trust’s standard operating procedures relating to controlled drugs (CDs) which was also identified during this inspection. During this inspection, we saw that the ordering, receipt and disposal of controlled drugs were carried out in accordance with the Misuse of Drugs Regulations 2001. However, we found the following issues:
• The trust’s CDs and the patient’s own medicines (CDs) were not stored on separate shelves on most wards which meant that there was a risk of these medicines being administered as stock.
• Concerns with the registering and recording of patient’s own medicines (CDs). Staff were recording more than one patient’s own CD per page.
• Documentation made it difficult to identify when a patient’s own medicine had been administered.
• We found dates missing on the CD register which made it difficult to ascertain which medicines had been used.

Following our concerns to the trust regarding CD management they took immediate steps to ensure patient’s own CDs were stored separately from stock-controlled drugs and recorded separately in the controlled drugs register. They informed us they had updated their policy to reflect the amendments to the way patient’s own medicines were recorded. Four wards required new CD cabinets to accommodate the change in policy which are due to be installed by the end of September 2019. A risk assessment for those areas had been completed.

Staff did not always follow systems and processes when safely prescribing, administering and recording medicines. We looked at eight medication administration records (MAR) and found the following concerns which were escalated to either the matron, manager or nurse in charge. We found concerns on the following wards 8A, 7BN and 5A:

• Gaps in the administration of medicines.
• Instructions for the discontinuation or administration of medicines on post-it notes which were not dated. This meant there was a risk of the post-it notes going missing and/or the patient being given the medicine incorrectly as the instructions were unclear.
• Duplication of medicine on a patient’s MAR. This was brought to the attention of staff who immediately addressed our concerns and got a doctor to review and cancel one of the instructions.
• Some entries were indecipherable which could lead to errors.

Ward pharmacists checked drugs charts daily, pharmacists clarified with the prescriber and printed the name above the medicine when it was difficult to read. Pharmacists spoken with confirmed this was a continuous and timely process with them having to track doctors to verify the written prescriptions. We noted that from the records seen, one patient on ward 8A had not received their anticonvulsant medicine as they were away from the ward, but there was no indication this had been given on their return. This was highlighted to the matron who requested the completion of an incident report, so this could be identified as an area for learning. This meant that we could not be assured that incidents were recorded appropriately. This was brought to the attention of the trust who informed us that following the inspection all doses of critical medicines were being audited monthly. Evidence seen showed a sustained improvement in the percentage of critical drugs omitted or delayed from 7% to below 3.5% for the last twelve months. Any medicine omitted or delayed should have been reported on the trust’s electronic incident system and the case highlighted during the inspection, with the omitted anticonvulsant medication, was currently going through the learning review process. However, staff informed us that they did not routinely complete an incident form when time critical medicines were due but may have been omitted should the patient be away from the ward. This meant that we could not be assured that staff were following trust procedures in the management and administration of time critical medicines.
Medicines were stored securely in all clinical areas. All medicines were kept in locked cupboards with only appropriate staff having access to keys or coded door numbers. However, staff did not always monitor, and record temperatures of fridges used to store medicines, to ensure that medicines kept within the fridges were at the required temperature range. Staff we spoke with confirmed that all out of range fridge temperature recordings must be recorded in the action log in the fridge temperature monitoring book. The entry should indicate the problem and the action taken. If this was unresolved it would be escalated to the ward pharmacist. We reviewed the fridge temperature checks and found no evidence that out of range fridge temperatures were reported. For example, we saw two occasions in June 2019 on ward 5B where the temperature exceeded the required temperature for over five days but found no recorded action that this had been escalated or managed.

Staff followed current national practice to check patients had the correct medicines. There was a medicines optimisation strategy in place for 2019 to 2022. The aim of the strategy was to ensure that the right patient got the right choice of medicine at the right time while ensuring that the trust delivered high quality care consistently across all services. The strategy was in line with the National Institute for Health and Care Excellence (NICE) “Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes’ [NG5] in March 2015” and the Royal Pharmaceutical Society (RPS) published document called ‘Medicines Optimisation: Helping patients to make the most of medicines’ (May 2013). Examples of the key priorities were:

- To produce a bi-annual medicines optimisation report to demonstrate an improvement in the medicine’s optimisation framework.
- To develop and finalise the medicines optimisation dashboard.
- Medication errors and harm are measured, and lessons learned at the bi-monthly medication forum, and at the harms free care group.

The nursing and midwifery quality indicators for June 2019 showed that across the surgical division 92% of medicines had been administered as prescribed. The quality and safety report for April 2019 identified there had also been a reduction in the administration of time critical medicine doses omitted. Critical medicines are those where a delay or omission could have a serious detrimental effect to the patient for example; medicines used for managing Parkinson’s disease or diabetes. During the inspection staff informed us how they were notified during handover and the daily huddle of patients who required critical medicine doses.

Pharmacists checked that antibiotic prescribing was in line with the trust’s antimicrobial guidelines. This included checking that the reason for prescribing an antibiotic was documented on the medicine record and the length of treatment was recorded. The pharmacy dashboard provided by the trust showed that from March to July 2019 the service met the trust target of 90%, except for May 2019, which was just below at 88%.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The accountability report for June 2019 identified there had been 17 medication errors of which one resulted in moderate harm (anaphylaxis to antibiotic - not a known allergy,) and four patients had been prescribed incorrect intravenous antibiotics for sepsis arising from a urine infection. We saw the recommendation which included the service working with pharmacists to identify themes and to ensure shared learning across the division. Staff we spoke with confirmed they discussed medicine incidents during their daily huddle and team meetings. This was observed during a shift handover and daily huddle.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. Staff we spoke with confirmed there were processes to ensure patients received the appropriate medicines. For example, we observed a
patient dependent on alcohol being offered medicines to assist with their withdrawal and associated side-effects. The records seen showed that prior to the use of the medicines this had been discussed with the patient and their relative.

Incidents

While the service managed patient safety incidents well staff did not always report all incidents. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff did not always report all incidents that they should report. For example, we found gaps in the administration of medicines. Staff informed us that this should be followed up by an incident report. This was discussed with the matron responsible for wards 7BN, 7BS, and 8A who confirmed they had not received incidents regarding our findings. This meant that we could not be assured that staff understood when incidents should be reported or that senior managers had oversight of events happening on the wards.

The accountability review meeting report for July 2019 identified that while there was a good trend downwards in incidents of moderate and above harm they would have expected to see higher reporting and had recommended an increase in divisional learning.

Never Events

The service had reported three never events within surgery.

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

From June 2018 to May 2019, the trust reported three incidents that were classified as never events in surgery.

All three incidents occurred at Lister Hospital and were classified as wrong site surgery. *(Source: Strategic Executive Information System (STEIS))*

We saw the risk of further never events was included on the trust risk register (6041). The risk register acknowledged and recorded the actions undertaken which meant the service had processes and procedures to review and manage the risk. Areas covered included:

- safer surgery work group established looking at National Safety Standards for Invasive Procedures (NatSSIPs). *(The aim of NatSSIPs was to reduce the number of patient safety incidents relating to invasive procedures in which surgical never events could occur).*
- Action plan implementation reviewed by the action closure group.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong. 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 duty of candour principles was included within the patient safety presentation at doctors’
induction, annual patient safety training for foundation year one and two doctors, preceptorship study day for nurses and root cause analysis training. Duty of candour compliance was managed and monitored through the trust’s electronic incident reporting system. There was a dedicated section on the trust’s intranet called “being open/duty of candour” which was accessed via the patient safety page. This provided access to key information such as letter templates and guidance. There had been eight cases where the duty of candour had been applied within the surgical service. We saw from investigations that the service had applied duty of candour appropriately following serious incidents which included feedback to patients. (Source: P30).

**Breakdown of serious incidents reported to STEIS**

The trust reported to the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports and the Strategic Executive Information System (STEIS). STEIS is a system used to report and monitor the progress of serious incident investigations across the NHS.

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2018 to May 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>4</td>
<td>28.6%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>3</td>
<td>21.4%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>2</td>
<td>14.3%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>2</td>
<td>14.3%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Operation/treatment given without valid consent</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td>Medical equipment/ devices/disposables incident meeting SI criteria</td>
<td>1</td>
<td>7.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Managers debriefed and supported staff after any serious incident. For example, we visited a ward and were informed of a serious incident which had occurred the previous evening. Staff we spoke with confirmed the processes taken which included debriefing staff. The nurse in charge confirmed they were actively ensuring the well-being of their staff and providing the appropriate support throughout the shift. We observed this practice in place during the inspection.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There had been a total of 2,647 incidents within the surgical division from July 2018 to June 2019 with the number of incidents causing harm (death, severe, moderate and minimal) at 415. (Source: DR128 Surgery accountability report July 2019). The June 2019 surgery clinical governance group minutes showed the number of open actions being tracked and actioned had come down to 145.

Staff received feedback from investigation of incidents, both internal and external to the service. Senior staff said they shared appropriate information during team meetings and daily huddles to
ensure lessons were shared. We observed incidents being discussed at daily huddles. We noted that huddles were recorded which enabled staff to read and review should they not be on that shift.

Staff met to discuss the feedback and look at improvements to patient care. The trust’s Hospital Standardised Mortality Ratio (HSMR) performance aimed to improve patient outcomes. This was an indicator of healthcare quality that measures whether the number of deaths in hospital was higher or lower than you would expect. The latest HSMR for the rolling 12 months to December 2018 was 93.0 which was “better than expected” against the national average of 100 for January 2019. (Source: P82). We reviewed the mortality and morbidity meeting minutes for April 2019 and saw there was a discussion of each case and learning points were identified where appropriate.

The trust’s Hospital Standardised Mortality Ratio (HSMR) performance aimed to improve patient outcomes. This was an indicator of healthcare quality that measures whether the number of deaths in hospital was higher or lower than you would expect. The latest HSMR for the rolling 12 months to December 2018 was 93.0 which was “better than expected” against the national average of 100 for January 2019. (Source: P82). We reviewed the mortality and morbidity meeting minutes for April 2019 and saw there was a discussion of each case and learning points were identified where appropriate.

The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. The SHMI had remained in the “as expected” range from the inception of the mortality indicator. The SHMI score for the rolling 12 months to September 2018 was 99.9 which was on par with the England figure of 1.0. (Source: Trust board meeting papers April 2019).

The service had access to the policy and procedures in place for the learning disabilities mortality review (LeDeR) to ensure they had oversight and investigated the death of a person with a learning disability, autism or both while using the services. There were processes to cascade lessons learnt from the findings of these investigations which included feedback during team huddles. (Source P80).

Staff confirmed that they received feedback. Medical staff informed us that there was good learning from incidents and that all incidents were discussed at their monthly rolling half-day meetings.

There was evidence that changes had been made as a result of feedback. The trust informed us that they had implemented a bed checklist because of a never event on a surgical ward. However, although staff were aware of the checklist and guided us to blank copies, none had been completed in the 17 records seen, apart from one on ward 8A. This meant that we could not be assured of changes being effectively implemented and reviewed across the surgical division.

Most managers shared learning about never events with their staff and across the trust. Nursing staff confirmed this had been cascaded during a team huddle and they had also received an e-mail to enable shared learning. However, most of the theatre staff we spoke with were unaware of the wrong site surgery never events and were unable to provide us with any recommendations or learning. We saw that the incidences of never events were discussed at the quality and safety committee meeting of April 2019. The accountability review meeting for July 2019 identified that the hospital had achieved over 250 days since the last never event and there was a recommendation to increase divisional learning around incident reporting.

We found no evidence that managers shared learning with their staff about never events that happened elsewhere. Staff we spoke within theatres were unable to provide us with any shared learning of never events that had occurred across the trust.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see.

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 10 new pressure ulcers, three falls with harm and two new catheter acquired urinary tract infections from May 2018 to May 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at East and North Hertfordshire NHS Trust**

1. Total Pressure ulcers (10)

2. Total Falls (3)

3. Total CUTIs (2)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

**Staff used the safety thermometer data to further improve services.** The ward managers explained the actions they took to minimise the risk of avoidable harms. Where the ward managers found issues relating to care, they raised them either with staff directly or reinforced the messages at the morning and evening safety brief. These were documented for staff to review and read which meant that there were processes to review and manage safety across the service.

**Safety Alerts**

The service planned for emergencies and staff understood their roles if one should happen.

The trust remained at a “substantially compliant” level against the NHS England emergency, preparedness, resilience and response (EPRR) guidance and framework.

The surgical service had a planned departmental business continuity plan which had been approved at divisional board level.
Senior staff confirmed they were provided with updates regarding any safety alerts for the service which they responded to accordingly. Major incident training was included within the trust induction. Wards had clear actions staff needed to take in the event of an electric failure or other major incident. The hospital had back-up generators to ensure an uninterrupted power supply if the mains supply failed. Staff completed fire safety training as part of their mandatory training. Compliance rates were 87% for nursing staff and 77% for medical staff which was below the trust target of 90%.

Nursing and medical staff we spoke with described the evacuation procedures which included how to evacuate patients and meet at their allocated meeting points. All fire safety equipment checked on the medical wards/units we visited were fit for use.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A wide range of policies and guidelines were available for staff. They were based on national guidance and provided references to these. Updates on new policies were communicated via e-mails and discussed during team and governance meetings. The service was compliant with National Institute for the Health and Care Excellence (NICE) guidance CG50 ‘Acute Illness, Recognising and Responding to the deteriorating patient in all clinical areas.” For example; we saw the wards were using the National Early Warning Scoring 2 (NEWS 2) system and no issues or concerns were found during the inspection.

Other national and local guidance were displayed on noticeboards within the ward areas. This included hydration and fluid balance, pressure ulcer prevention, and falls prevention and management information.

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 which ensured traceability at national level, if concerns were raised about the quality of joints, or any adverse effects.

The pre-operative assessment clinics 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.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. We saw that patients who may have been frail or vulnerable received or were referred for a comprehensive assessment for their mental well-being. We saw the records of two patients who had been the subject of a Mental Health Act assessment and noted that the documentation followed the code of practice. This meant the trust had processes in place to ensure that all patients received the appropriate quality of care.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a handover where the care and treatment required for each patient was reviewed. This referred to the patient’s psychological and emotional
needs as required. The handover team also identified any concerns with family and relatives or whether any contact was required to ascertain additional knowledge.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. While they used special feeding and hydration techniques when necessary we found staff did not fully and accurately complete patients’ fluid and nutrition charts where needed. The service made adjustments for patients’ religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed both nursing and housekeeping staff ensuring that patients had access to water which was within their reach. Staff said they could access a sandwich and a drink for patients who may have arrived onto the ward late. Wards had long periods of time when they were open to visitors. Although the wards did not have protected patient mealtimes, medicines were not routinely administered during mealtimes to allow patients time to eat without interruption. Family members were encouraged to attend and support their relative at mealtimes.

Staff did not fully and accurately complete patients’ fluid and nutrition charts where needed. Patient’s nutrition and hydration needs were assessed on admission and monitored using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: ‘Physical and psychological needs’ (2012). When staff identified risk, they introduced food and drink intake charts and allocated a red tray to the patient to indicate the need for support with eating. The recording of the input and output of fluid in the body allows metabolic processes to function correctly and reduce dehydration. We visited wards 5A, 7BS, 7BN and 8A and found that they did not accurately record fluid and nutritional charts. We looked at 17 charts and found that most were partially completed, and the balance total was missing in most of the records.

We looked at the record of a patient and saw they had been declining fluid and food. We noted that a referral to a dietitian had not been made and this was raised as a concern to the nurse in charge. They immediately reviewed our concerns and arranged for a referral to be made to the dietitian. The July 2019 documentation audit for nutrition scored 91% across the surgical division. However, we noted that for the question “If the patient should be on a food chart, has this been completed for each meal, and has each entry been dated and signed” scored 76% and “if the patient requires assistance at mealtimes, is it documented that the red tray system has been implemented” scored 72%. (Source: DR103). This meant that we were not assured that there were systems and processes in place to oversee the documentation to support the needs of patients.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Speech and language therapists and dietitians reviewed patients who had been referred to them. We looked at the record of a patient who required input from both the dietitians and language therapist. The nursing records referenced the referral, but it was difficult to find the outcome which was located within the medical records. Neither the medical administration records or the nursing notes referenced that the patient had received a review and staff we spoke with were unaware of the outcome which provided guidance on how to manage the patient’s needs during and after eating and having their medicines. This meant that there was a risk that patients may not receive the appropriate treatment suitable for their needs such as having a soft diet.
Patients waiting to have surgery were not left nil by mouth for long periods. Prior to surgery patients were kept 'nil by mouth' and fasted in accordance with national safety guidance, to reduce the risks of aspiration during general anaesthesia. We attended a clinic and observed elective patients being given clear instructions about fasting prior to admission. Information was given verbally during the assessment and in writing. Most of the patients we spoke with, told us they had been taken down to theatre about the time they were expecting to go and did not have an extended wait, thus avoiding a lengthy fasting period. However, we identified that some patients were asked to attend the theatre admissions unit for their surgery at 7.30am and they might not go to theatre until the afternoon. This was done to accommodate possible changes to the theatre list, particularly if the trust was facing capacity issues. This meant that some patients may have fasted for long periods of time. When this happened, staff said they liaised with the anaesthetist and provided patients with sips of clear drinks if applicable.

Pain relief

Staff assessed and monitored patients regularly to see if they were in and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was risk assessed and documented using the enhanced nursing care bundle which included pain management chart. Patients were also reviewed during the patients’ intentional care rounding (a structured process of carrying out regular checks with individual patients at set intervals). The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). We saw that patients with acute pain had an individualised plan appropriate to their condition. Pain was assessed during observations and recorded appropriately. Patients we spoke with said they were asked if they were in any pain during interactions with staff and had been given pain relief in a timely manner. The service had access to a pain team for advice and support when required. We observed staff discussing pain during handovers and any identified concerns were referred to the consultant.

Staff said they would observe patients’ facial expressions, body language and a change in behaviour, to ascertain if they were uncomfortable, if they were unable to communicate with them. During the inspection, we looked at 17 records and found that while the pain management had been completed the enhanced nursing care bundle had not been checked by the registered nurse as outlined in the documentation which meant that we could not be assured that staff had oversight of the management of the patients’ daily needs.

Patients received pain relief soon after requesting it. During the inspection we observed staff discussing pain with patients and providing the appropriate pain relief in a timely manner.

Staff prescribed, administered and recorded all pain relief accurately. We found no issues or concerns with the administration and recording of pain relief to patients. 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. We saw recovery staff monitoring patients pain and administering appropriate analgesia promptly. The nursing and midwifery quality indicators audit for March 2019 showed 92% compliance with pain management.
Patient outcomes

While staff monitored the effectiveness of care and treatment and used the findings to make improvements not all identified actions had an accompanying outcome which meant that we could not evidence the oversight of the progress made.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers used the results to improve services further. The new clinical audit and effectiveness quality governance group (CAEQGG) was responsible for overseeing the method for agreeing the topics for the trust mandatory audits. The audit ensured that the following areas were considered; national clinical audits, NICE guidance, local-specialty priorities, re-audits and National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

The trust participated in the Commissioning for Quality and Innovation (CQUIN) national goals. The aim of the CQUIN framework is to improve the quality of services and provide better outcomes for patients. For example; reducing the impact of serious infections (including sepsis) and staff health and wellbeing. Sepsis is a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs.

Managers carried out a comprehensive audit programme. Staff completed a monthly nursing and midwifery quality indicator which covered a range of areas including; bed occupancy, staffing, patient safety and patient experience.

Managers used information from the audits to improve care and treatment. Staff informed us that they were given feedback at daily huddles should a concern or issue be identified on the nursing and midwifery quality indicators audit. Staff also said that managers fed back lessons learnt from meetings they attended.

There were engagement meetings and/or follow-up of audit outliers. The service collected data for all total hip and knee replacements and fractured neck of femurs. From April to June 2018, the surgical site infection (SSI) rate for total knee replacement increased to 3.1% (benchmark 0.5%) and the trust had been identified as a high outlier. (Source: P67) Senior staff we spoke with said they were aware of the concerns and had implemented an action plan to manage this. We saw the July 2019 improvement plan for the reduction of SSI. This was RAG (red, amber, green) rated and included the goal and the action and progress taken. For example, one goal was to restrict theatre traffic and opening of theatre doors during surgery to exceptional movement only and the progress taken which included repeat audits in place with baseline data recorded to monitor improvement completed July 2019. It was planned to present this to the trauma and orthopaedic management meeting in September 2019. Goals rated as red included: standard competency of staff for scrubbing and draping and assurance required that national standards of practice have been met. The first action did not have a completion date while the other was due by October 2019. (Source DR102)

Managers shared and made sure staff understood information from the audits. The trust had introduced the “Getting it Right First Time” (GIRFT) programme. We saw the GIRFT orthopaedics action plan (Source: P118) for March 2019 which included the recommendations, actions taken, the completion date and who was responsible for the action. We noted that the completion dates were July and September 2019. For example, one action was to improve theatres utilisation; reduce cancellations, late starts and early finishes by reviewing a GIRFT time and motion of theatre processes (July 2019). However, the identified actions did not have any outcomes which meant that we could not evidence the oversight of the progress made against the actions.
The trust had a quality transformation programme (2018-2019) whose priority was to strengthen the service’s approach to clinical audits and effectiveness. During 2018/2019 the trust participated in 98% (58 of the 59) eligible national clinical audits and 100% (7 of the 7) eligible national confidential enquiries.

Embedding the national learning from deaths framework had been a continued focus and priority for the trust. There was a trust wide review of mortality bi-monthly, led by the medical director regarding the learning from deaths.

**Improvement was checked and monitored.**

The trust’s Hospital Standardised Mortality Ratio (HSMR) performance aimed to improve patient outcomes. The quality and safety meeting minutes (April 2019) showed that the latest HSMR for the rolling 12 months to December 2018 was 93.1 which was “better than expected.”

![HSMR rolling 12-months](image1)

(Source: P82 Quality and safety meeting minutes April 2019)

The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. The quarterly SHMI figure improved to 102.7 in quarter one (2018/2019) and then improved further to 99.9 in quarter two of 2018/2019. This was the first time the SHMI had been below 100 since its inception in 2010.

![SHMI quarterly](image2)

(Source: P82 Quality and safety meeting minutes April 2019)
Relative risk of readmission

Lister Hospital

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 represents the opposite. Top three specialties for specific site based on count of activity

From February 2018 to January 2019, patients at Lister Hospital had a higher expected risk of readmission for elective admissions when compared to the England average of 100.

- Urology patients at Lister Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Lister Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Ear, nose and throat (ENT) patients at Lister Hospital had a higher 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 represents the opposite. Top three specialties for specific site based on count of activity

From February 2018 to January 2019, patients at Lister Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average of 100.

- General surgery patients at Lister Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Plastic surgery patients at Lister Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedic patients at Lister Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

*(Source: Hospital Episode Statistics)*
National Hip Fracture Database

Lister Hospital

The table below summarises Lister Hospital’s performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results nationally.

<table>
<thead>
<tr>
<th>Metrics (Audit indicators)</th>
<th>Hospital performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>102.3%</td>
<td>Similar</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of patients having surgery on the day or day after admission (It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</td>
<td>81.5%</td>
<td>Better</td>
<td>x</td>
</tr>
<tr>
<td>Crude peri-operative medical assessment rate (NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</td>
<td>98.0%</td>
<td>Better</td>
<td>x</td>
</tr>
<tr>
<td>Crude proportion of patients documented as not developing a pressure ulcer (Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient’s admission); this measures an organisation’s ability to report ‘documented as no pressure ulcer’ for a patient)</td>
<td>97.5%</td>
<td>Similar</td>
<td>x</td>
</tr>
<tr>
<td>Crude overall hospital length of stay (A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</td>
<td>15.1 days</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day mortality rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>7.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Hip Fracture Database)
## Bowel Cancer Audit

The table below summarises the trust's performance in the 2018 National Bowel Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>108.7%</td>
<td>Good</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection (A prolonged length of stay can pose risks to patients)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate (Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate (Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</td>
<td>21.0%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate (A potential risk for early/inappropriate discharge is the need for unplanned readmission)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection (After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</td>
<td>57.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

The trust provided us with an action plan based on the bowel screening cancer audit. The action plan identified the recommendations, time scale and evidence required. However, this did not have any outcomes to identify what had been implemented against the evidence required which meant that it was difficult to assess what improvements the service had made. (Source: DR128)
National Vascular Registry

The table below summarises the trust’s performance in the 2018 National Vascular Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Surgery (Surgical procedure performed on an enlarged major blood vessel in the abdomen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>90%</td>
<td>Not applicable</td>
<td>✓</td>
</tr>
<tr>
<td>Risk-adjusted post-operative in-hospital mortality rate (Proportion of patients who die in hospital after having had an operation)</td>
<td>0.0%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Carotid endarterectomy (Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>85.0%</td>
<td>Not applicable</td>
<td>✗</td>
</tr>
<tr>
<td>Crude median time from symptom to surgery (Average amount of time patients wait to have surgery after the onset of their symptoms)</td>
<td>5 days</td>
<td>Not applicable</td>
<td>✓</td>
</tr>
<tr>
<td>Risk adjusted 30-day mortality and stroke rate (Proportion of patients who die or have a stroke within 30 days of their operation)</td>
<td>3.3%</td>
<td>Within the expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises the trust’s performance in the 2018 National Oesophago-gastric Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics (Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>81 to 90%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
<tr>
<td>Age and sex adjusted proportion of patients diagnosed after an emergency admission (Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor)</td>
<td>12.4%</td>
<td>Better</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
rates of survival. The audit recommends that overall rates over 15% could warrant investigation

<table>
<thead>
<tr>
<th>Risk adjusted 90-day post-operative mortality rate (Proportion of patients who die within 90 days of their operation)</th>
<th>Not eligible</th>
<th>Not eligible</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Alliance level metrics (Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients treated with curative intent in the Cancer Alliance (Proportion of patients receiving treatment intended to cure their cancer)</td>
<td>37.7%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Oesophago-Gastric Cancer Audit)

The quality report for 2018/2019 located within the quality and safety report of April 2019 identified the following actions which was confirmed as ongoing by senior staff:
- Data needs to be uploaded to NOGCA
- Ongoing review of audit results guide

**National Emergency Laparotomy Audit**

**Lister Hospital**

The table below summarises Lister Hospital’s performance in the 2017 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>100%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death (Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td>34%</td>
<td>Red</td>
<td>✗</td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times)</td>
<td>96%</td>
<td>Green</td>
<td>✓</td>
</tr>
<tr>
<td>Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon)</td>
<td>73%</td>
<td>Amber</td>
<td>✗</td>
</tr>
</tbody>
</table>
and Anaesthetist present at the time of their operation)  

<table>
<thead>
<tr>
<th>Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</th>
<th>82%</th>
<th>Amber</th>
<th>×</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</td>
<td>13%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Emergency Laparotomy Audit)

The service had completed an action plan based on the results of the NELA report. The trust also updated the outcomes of the NELA audit in its accountability review meeting (ARM) surgical division report for month three (June 2019). We saw examples of the updated outcomes which included:

- 91% of patients admitted to critical care following surgery when the risk of death >5%. This was above the national mean of 83%.
- Postoperative length of stay was just above the national mean of 11 days at 12 days.
- 100% consultant surgeon in theatre when the risk of death was >5%. This was above the national mean of 95%.

The NELA report was also discussed at the clinical governance rolling half-day (16 July 2019) with emphasis made on the requirement for consultant anaesthetist presence during high risk laparotomies. However, it was noted that while the NELA action plan (rated red amber green (RAG)) had identified current practice, evidence and actions needed to implement recommendations this did not have any dates as to when they should be completed. For example, 17 of the actions had been completed (rated green – 100% compliance) but there were 18 outstanding (rated red (0-59% non-compliance) actions for the December 2016 to November 2017 (published December 2018). (Source: DR128)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises the trust’s performance in the 2018 National Ophthalmology Database Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison on to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-level metrics (Measures of hospital performance in the treatment of cataracts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment (Proportion of eligible cases included in the audit)</td>
<td>0.0%</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)</td>
<td>No data available</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted visual acuity loss</td>
<td>No data</td>
<td>n/a</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(The most important outcome following cataract surgery is the clarity of vision)

(Source: National Ophthalmology Database Audit)

The trust informed us that for a third year they were not able to participate in the National Ophthalmology audit due to the lack of funds available to purchase and install the required software. The risk of not participating in this quality account audit had been added to the risk register.

National Joint Registry (NJR)

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Lister Hospital

The table below summarises Lister Hospital’s performance in the 2018 National Joint Registry.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients consented to have personal details included <em>(hips, knees, ankles and elbows)</em> <em>(Patient details help ‘track and trace’ prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</em></td>
<td>95.6%</td>
<td>Better</td>
<td>✗</td>
</tr>
<tr>
<td>Risk-adjusted 5-year revision ratio <em>(for hips excluding tumours and neck of femur fracture)</em> <em>(Proportion of patients who need their hip replacement ‘re-doing’)</em></td>
<td>1.2</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio <em>(for hips excluding tumours and neck of femur fracture)</em> <em>(Proportion of patients who die within 90 days of their operation)</em></td>
<td>1.6</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Risk-adjusted 5-year revision ratio <em>(for knees excluding tumours)</em> <em>(Proportion of patients who need their knee replacement ‘re-doing’)</em></td>
<td>1.3</td>
<td>Within expected range</td>
<td>✗</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality ratio <em>(for knees excluding tumours)</em> <em>(Proportion of patients who die within 90 days of their operation)</em></td>
<td>1.0</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

The trust informed us they were audited on their compliance with uploading of the national joint registry forms containing; who operated, patient information, type of joint replacement and reason for operation, and patient consent. They were currently waiting the 2018/19 performance results to be published and expected to be in the same position which was “better than average” based
on the audit results. The service informed us they were working with the emergency department to work on this cohort of patients regarding consent and would visit patients on the wards or write to them retrospectively. (Source: DR128)

National Prostate Cancer Audit

The table below summarises the trust’s performance in the 2018 National Prostate Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men with complete information to determine disease status (This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)</td>
<td>94.9%</td>
<td>N/A</td>
<td>✗</td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy (A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)</td>
<td>12.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy (Complications following surgery may reflect the quality of surgical care)</td>
<td>12.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy (External beam radiotherapy uses high-energy beams to destroy cancer cells)</td>
<td>8.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Prostate Cancer Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways. Descriptions of some of
the indicators presented are below.

Visual analogue scale (EQ VAS) is asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific issues namely mobility, self-care, usual activities, pain or discomfort, anxiety or depression. The EQ-5D-5L indicator uses five levels of responsiveness to measure problems. The range is; no problem to disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living. A simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.

In 2016/17 performance for groin hernias was better than the England average for the EQ-5D indicator and similar to the England average for the EQ VAS indicator.

For varicose veins, performance was better than the England average all three indicators.

For hip replacements, performance was about the same as the England average for all three indicators.

For knee replacements performance was variable between indicators. For the EQ VAS indicator, the trust’s performance was worse than the England average. For the EQ-5D index performance was better and the Oxford knee score was about the same as the England average.

(Source: NHS Digital)

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 and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Medical staff we spoke with confirmed that the surgical service provided a supportive training environment and that their educational needs were well met. Junior doctors confirmed that
they were supervised with unimpeded access to a consultant. They agreed there was a good balance between the level of supervision and autonomy and that consultants were easy to approach for assistance when needed. They confirmed they had to demonstrate their competence in relevant areas before working solo.

We saw staff were trained in sepsis management to recognise the deterioration of a patient. All doctors were trained on induction and were 100% compliant.

The March 2018 inspection identified that surgical staff had not received training for screening and application of a sepsis protocol. During this inspection, we saw the trust had achieved 97% for quarter one (April to June 2018) and 81% for quarter two (July – September). *(Source: P82 Quality and safety meeting minutes April 2019).*

We saw compliance folders on for example ward 7BN which included sepsis awareness training. Staff explained the escalation process for sepsis and told us they could contact the sepsis team for support when required. Sepsis had been mentioned in a recent “message of the week” and a speaker had attended one of their team meetings. The trust informed us that 90% of nursing staff would have completed sepsis training by the end of August 2019.

**Surgery sepsis training**

<table>
<thead>
<tr>
<th>Wards</th>
<th>Sepsis %</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A</td>
<td>70</td>
</tr>
<tr>
<td>5B</td>
<td>60</td>
</tr>
<tr>
<td>7B</td>
<td>73</td>
</tr>
<tr>
<td>8A</td>
<td>94</td>
</tr>
<tr>
<td>8B</td>
<td>85</td>
</tr>
<tr>
<td>11b</td>
<td>89</td>
</tr>
<tr>
<td>SAU</td>
<td>100</td>
</tr>
<tr>
<td>SWIFT</td>
<td>80</td>
</tr>
</tbody>
</table>

*(Source: DR100 provided by the trust)*

Staff received training on medical devices. The trust informed us that three of the surgical wards were 100% compliant and that it was planned that wards 5A and 5B would be 90% compliant by end of August, once new staff had completed their competencies.

The trust also informed us that staff on wards 11B, 8A and 5A would be 90% competent in syringe driver use by the end of August 2019. *(Source DR113)*

Theatre, anaesthetic and recovery staff were assessed as competent for the pieces of equipment they would be exposed to use within their area of speciality. When staff moved speciality, they informed us that they were assessed to ensure they became competent on new equipment.

Nursing and clinical support workers working within the minor operations area (Ward 11B) were trained and had their competency assessed to ensure they could work without supervision. They were responsible for completing pre-operative paperwork with the patient and assisting the surgeon during the procedure. All staff working on ward 11B were supported by the allocated senior nurse in charge.

Managers gave all new staff a full induction tailored to their role before they started work. Senior staff confirmed that all locums received an induction to the service and that there were a high number of locum slots that were filled either within the department or by returning locums. Locums we spoke with confirmed they had received an induction, were supported well and enjoyed working at the hospital.
Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal uptake rates across the division had declined and were currently at 80% which was below the trust target of 90%. The surgical division accountability review meeting report (June 2019) stated that the division had not reached 85% in the last 15 months. There were 190 appraisals outstanding of which 90 was in anaesthetics and theatres. Human resources business partners were working with divisional leadership teams to develop improvement plans and agree an improvement on the trajectory.

Surgery Appraisal performance

(Source: DR129 July 2019 accountability review meeting (surgery))

Wards and theatre managers had systems to monitor whose appraisal was due. All staff we spoke with during the inspection told us they had received an appraisal within the last 12 months. We observed that both nursing and medical staff had the skills and experience to deliver effective care and treatment to patients. Nursing staff and care support workers (CSW) described ways in which they managed and cared for patients. They confirmed they were able to develop their role through mentoring and support from each other.

From April 2018 to March 2019, 74.9% of required staff in surgery received an appraisal compared to the trust target of 90%. The trust target was not met for any staff group in surgery.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>6</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>32</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>85</td>
</tr>
</tbody>
</table>
Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust held monthly multi professional preceptorship forums for newly qualified staff. These forums were facilitated by senior members of staff and provided a platform, in a confidential environment, for staff to reflect on their practice, raise any concerns or share their experience.

The re-launch of the rolling half day programme in 2018/2019 enabled specialties to present audits, share findings and disseminate learning. We saw the July 2019 minutes for, gastroenterology and urology which included a review of updated policies, learning from incidents, duty of candour presentation and mortality reviews.

Medical and nursing staff told us that they had support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely.

There were enough clinical educators to support staff learning and development. Theatres had two practice educators and staff said they were very beneficial and praised the teaching and support they received.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Ward managers said that the monthly meetings and/or one-to-one meetings adopted a coaching style approach to develop and promote development and outcomes. This was confirmed by staff we spoke with.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Nursing and therapies staff told us they were encouraged to access additional training and development to extend their skills.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff said the trust ensured that education and training programmes were provided to enable staff to develop the additional skills they needed to function safely and effectively in their roles. For example, surgical specialties were looking at developing advanced nurse practitioner roles with training provided to extend the skills of staff and enable them to provide support to junior doctors. We also spoke with two staff who had just qualified as associate nurses. They were excited about the opportunities their new roles provided and how they could contribute on the wards. Care support workers we spoke with said they had access to forums which were part education and part a platform of sharing and raising areas of practice.

Senior staff said they provided post incident support to staff. This was an unscheduled informal process that provided support and learning following incidences. We saw senior staff supporting staff after an incident that had occurred on the night shift on a ward.

Managers made sure staff received any specialist training for their role. Senior staff showed us competency folders which they had created to ensure that staff had the skills and knowledge for
their role. Staff confirmed they had received additional training, in for example; sepsis awareness, nasogastric (NG) feeding (a special tube that carries food and medicine to the stomach through the nose) and cannulation (the inserting of a tube into a patient’s vein).

Extended VTE prophylaxis in post-operative surgical cancer patients was identified as an area of concern. Results presented to the quality and safety meeting April 2019 identified additional teaching to junior doctors and the importance of clear documentation as well as the implementation of ward round proforma stickers. A re-audit was carried out which identified compliance with all areas which included; observations of vital signs, date, time and person leading the ward round. (Source: P82)

### Multidisciplinary Working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Throughout the inspection, we saw that effective multidisciplinary team (MDT) working practices were established and teams worked well together to improve the efficiency and timeliness of care. Staff could access dietitians, physiotherapists, safeguarding teams and the critical care outreach team who were able to provide support and advice when required.

The service held regular surgical multidisciplinary (MDT) meetings which were electronically recorded. We attended a meeting which had a cross sector of staff including other agencies such as community support workers who supported the patient discharge pathway. Occupational therapists tended to be involved in more complex cases, for example, those requiring specialist equipment. Physiotherapists used the updated electronic system which they said had improved communication.

We saw pharmacy staff on all the surgical wards that we visited and observed they interacted well with all members of the team. They were well utilised by medical and nursing staff, providing advice and support and monitoring medicines management. Medical and nursing staff praised pharmacy staff for their positive contribution.

Theatre and ward staff worked well together, and we observed this enabled theatre lists to run efficiently. However, one of the theatre staff told us there were frequent occasions when they had to take patients back to the ward following recovery from surgery, as ward staff were unable to attend to collect patients. They said they sometimes had to leave the patient in the bed space in a bay and hand over to the ward staff away from the patient. This was not considered to be good practice.

Staff worked across health care disciplines and with other agencies when required to care for patients. It was clear from observed interactions, that there was mutual respect for all team members. Staff were listened to, and senior team members made time for all staff, despite the increased activity and demand. Doctors and specialist practitioners were considered part of the team, with many specialty doctors basing themselves within the department. This ensured that they were available to discuss patients and offer support. Multidisciplinary ward and board rounds were well embedded on the medical wards which supported an effective handover between medical and nursing teams.
Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff confirmed they could request or make a referral for a visit from the rapid assessment, interface and discharge (RAID) team. RAID is a multidisciplinary mental health service working within the trust. They worked closely with the hospital psychologist and alcohol practitioners, as well as hospital clinicians. Staff said they could ask the RAID team for general advice and support when required. We saw good examples of staff supporting patients with complex needs to ensure they received parity of care.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. The delivery of seven-day services across England was a priority for NHS England which resulted in the trust carrying out a survey of the seven-day service provided. This was based on the seven-day hospital services board assurance framework. The results showed the trust met three of the four standards. For example, we saw that the trust was 100% compliant with twice daily review and 96% compliant with daily consultant review in relation to Standard 8: Patients who were highly dependent should be seen by a consultant twice daily. Records seen showed that consultants were available within their speciality from 7:30am to 6pm with out of hours on-call from home.

At the weekend there was an identified consultant on call for each surgical specialty and consultants from most specialties undertook daily ward rounds at weekends. There was a ‘post take’ ward round to ensure all newly admitted patients were seen. All patients in the surgical assessment unit (SAU) were seen by a consultant at least once daily. This complied with national guidance for seven-day services (NHS: Seven-day Services Clinical Standards, 2017 priority clinical standard 6).

Physiotherapists were allocated to the surgical wards Monday to Friday with a reduced service at weekends. For example, on Saturdays there were two physiotherapists who worked as part of their weekly rota. However, Sunday shifts were picked up on a voluntary basis only. There was a hospital wide physiotherapy on-call service over night.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. A consultant was on call for emergencies 24 hours a day, seven days a week. Junior doctors told us that consultants were supportive and accessible, even out of hours. Ward rounds took place daily on surgical wards including weekends. The surgical wards we visited had medical outliers who were seen by their appropriate consultant at least daily throughout the weekdays. A medical outlier is a patient that is admitted to another department/ward which is not medical, usually surgical wards. Doctors did not always see medical patients at weekends if their condition was stable.

Pharmacy offered a dispensary service Monday, Tuesday, Wednesday and Friday: 9.00 am to 5.30 pm (excluding bank holidays), Thursday: 9.30 am to 5.30 pm and Saturday; 9am to 12pm. The pharmacy team were developing a business case to establish funding requirements for a 9am to 5pm discharge service on Saturdays and Sundays. Ward-based clinical pharmacy services were available from 8am to 6pm. (Source: PIR P83).

Health promotion
Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Every effort was made to promote self-care with patients and carers, and achievable and realistic goals were set to improve their health. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients, including cancer care charities. Examples included; eating a healthy diet, moderating alcohol intake, increasing physical activity and smoking cessation. Staff confirmed they could arrange for these leaflets to be in a different language if the patient’s first language wasn’t English.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. An alcohol liaison specialist nurse supported acute patients and provided advice and support for patients transitioning to the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (MHA), Mental Capacity Act (MCA) 2005 and the Children Acts 1989 and 2004 and they knew how to contact for advice. Staff explained how they would support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. The trust had a memorandum of understanding with a local mental health trust to support them around the requirements of the MHA and supported working together to ensure every patient with a mental health need got to the right care setting as quickly as possible and was treated appropriately. This agreement confirmed the trust was meeting its statutory duties under the MHA while ensuring that best practice was being followed. Nursing staff confirmed staff deployed to the trust were invaluable and they could ask them for advice when required.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Medical and nursing staff explained the consent procedures and what to do if a patient lacked capacity to consent for care and treatment. Nurses understood when a patient might need to be assessed for a DoLS and understood what might constitute a deprivation of liberty.

Staff clearly recorded consent in the patients’ records. Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed authorised forms for treatment and exploratory investigations during the inspection. Therapy services had a consent pathway and we saw therapists confirmed consent in their written notes within the patients’ records.

The service carried out consent audits which we saw for April, May and June 2019. This was based on 30 elective cases. For example, we saw that six patients (20%) consented in the clinic and 24 (80%) consented on admission in June 2019. However, between 10% and 20% did not understand the nature of their illness and between 7% and 20% said they did not have enough
time with the surgeon to explore the questions that they might have had. The audit did not have any actions or outcomes which meant that we could not be assured that there were systems and processes to oversee the results of the audit. *(Source: DR121)*

We saw that consent was identified on the theatre 100-day work plan. The action was to roll out informed consent documentation to all specialties. It was identified that consent was an issue for surgical patients attending an outpatient clinic with the team only having 10 minutes for their clinics. Senior staff confirmed this continued to be a work in progress and were considering alternative methods of obtaining patient consent and were exploring the possibility of setting up consent only clinics.

During the inspection, we found that the patient’s capacity to consent to treatment was routinely checked. Staff said they completed Deprivation of Liberty Safeguards (DoLS) documentation for patients with suspected delirium. They confirmed this was preceded with a mental capacity assessment to assess the patient’s ability to consent for treatment and whether this was in their best interest. We found no issues or concerns in the records seen.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Medical and nursing staff outlined the principles of the MCA and the processes of how to support, assess and record decisions about care and treatment if patients lacked mental capacity and how to make “best interest” decisions. They spoke about how they supported patients to make decisions and knew of the role of the independent mental capacity advocates (IMCAs). We saw a referral for an IMCA for a patient who had no independent voice, family member or friend to represent them and two completed records where staff had undertaken mental capacity assessments, and best interest decisions in line with national guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We saw four consent forms which were completed fully with risks and benefits of the proposed procedure identified. When a patient was unable to give informed consent for a procedure, staff completed consent form four with a capacity assessment and the best interest decision making process. We did not see this form in use during the inspection.

Staff made sure patients consented to treatment based on all the information available. Nursing staff told us that most patients signed their consent form on the day of admission. This is not in line with current best practice guidance which states that consent should be gained prior to admission and re-visited on the day of surgery.

Staff gained written consent for interventions such as a blood transfusion and documented that verbal consent was gained, when patients were given treatments which did not require full written consent. We also saw signed consent for the taking of photographs within the records reviewed.

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

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 at trust level for qualified nursing staff in surgery is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>313</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>313</td>
</tr>
</tbody>
</table>

In surgery the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>214</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>220</td>
</tr>
</tbody>
</table>

In surgery the target was not met for either of the MCA/DOLS training modules for which medical staff were eligible.

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

The trust provided staff with Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training within the mandatory safeguarding training which was provided at induction, with updates every two years. Data provided by the trust showed that 89% of all surgical staff had completed their training which was just below the trust target of 90%. (Source: DR223)

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff confirmed that managers were supportive when they needed to complete a DoLS referral and they could also request support from the safeguarding team.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff explained how they would access the policy on the trust’s intranet system.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented DoLS safeguards in line with approved documentation. All DoLS referrals were submitted to the local authority DoLS team via an electronic link. We found no issues or concerns in the completion of the relevant forms in the records seen.
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. The response rate from the friends and family test was higher than the England average.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff members being courteous and helpful to patients and treating them with dignity and respect. During our inspection, we observed that staff of all levels introduced themselves and took time to interact in a considerate and sensitive manner. Staff spoke with patients in a respectful way and interacted well with them. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.

Patients said staff treated them well and with kindness. Patients praised staff for their kindness and understanding of their needs and were complimentary about the care they had received. One patient said that staff were “humorous and likeable” while another said, “all staff I’ve encountered have been welcoming, polite, professional and respected my dignity.” We saw numerous thank you cards on display throughout the service. Feedback included “staff are helpful and showed empathy” and “my stay was marvellous.”

Staff did not follow policy to keep patient care and treatment confidential. For example, during the inspection we found patient records left on surfaces which could be accessible to both patients and unauthorised personnel.

Wards used white boards to display patient names, their location in the ward and some treatment information. Hospital wards used these boards to display important information such as the patient’s infection risk, mobility, discharge readiness and lead consultant. The boards were visible to staff, patients and visitors to the wards. However, the boards did not contain the patients’ full names which maintained their confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff said that all patients were equal and that they did not differentiate should a patient have complex needs such as mental health. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. This was done in a way which was suitable to the patient’s individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate.

Friends and Family test performance

The overall Friends and Family Test (FFT) response rate for surgery at East and North Hertfordshire NHS Trust was 44.9% from April 2018 to March 2019. This was higher than the England average response rate of 24.2%.

A breakdown of response and recommendation rates by surgical ward can be viewed below. The percentage of respondents that said they would recommend the ward to family or friends was
90% or higher for all surgical wards for the 12 months overall.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp.</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery</td>
<td>4,816</td>
<td>44%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Swift Ward</td>
<td>1,013</td>
<td>45%</td>
<td>93%</td>
<td>92%</td>
</tr>
<tr>
<td>Ward 7B</td>
<td>969</td>
<td>44%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward 8B</td>
<td>706</td>
<td>43%</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>Ward 11B</td>
<td>576</td>
<td>52%</td>
<td>95%</td>
<td>89%</td>
</tr>
<tr>
<td>Ward 8A</td>
<td>549</td>
<td>55%</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 5A</td>
<td>517</td>
<td>39%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 5B</td>
<td>378</td>
<td>52%</td>
<td>90%</td>
<td>93%</td>
</tr>
</tbody>
</table>

**Key**

- Highest score to lowest score
- 100% 0% 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients were given information about relevant counselling services and peer support groups where applicable. Clinical nurse specialists were available for advice and support in several specialities including cancer and heart failure services.

We saw both nursing and medical staff involving patients and their relatives during assessments and when taking observations on the ward. If the patient’s relative had any questions, staff were able to discuss these at the time.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff understood the emotional stress of patients having anaesthetic prior to a procedure. We observed staff being supportive and reassuring patients before their procedure to minimise their anxiety and stress. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, “staff are really helpful, and I can ask them anything” while another said that staff were “were approachable and provided support when required.”

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Both doctor and nursing staff informed us that they were able to deliver difficult conversations in an environment away from the ward which they felt enabled them to be empathetic to the patient’s individual needs.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. The trust employed clinical nurse specialists in a range of surgical specialties. The clinical nurse specialists had received psychological support training and often saw patients both pre-operatively and post-operatively. In this way, they built positive and supportive relationships with patients. For those patients on the two-week cancer
pathway, nurses established contact with them at the telephone triage clinic and the same nurse followed them through the pathway.

Post-operative care within the recovery area was sympathetic and staff did everything they could to ensure patients were comfortable and free from any pain.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. The service had processes to ensure that it worked and engaged with patients receiving care, their families and carers, as set out in the NHS Constitution. Patients said they felt involved in their care and had been asked for permission and agreement first which meant that the views and preferences of patients were considered. Patients and relatives had been given the opportunity to speak with the consultant looking after them and they were complimentary about the way the way they had been treated by staff.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff confirmed they had systems in place to identify and support the communication needs of patients which included language interpreters, specialist advice or advocates. 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 information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

Communication aids such as symbols were available to ensure patients could understand and be involved in their care and treatment. We saw staff greeting patients by their first names and patients calling nursing staff by their first. Staff took time to explain information to patients in an appropriate manner while making sure patients knew how to contact them if they needed more information.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The health liaison team carried out service user evaluations to hear their views and experiences in hospital. The trust undertook joint research with an external hospital to gain the experiences of adults with a learning disability.

Staff supported patients to make informed decisions about their care. Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. We observed staff introduced themselves to patients and explained to patients and their relatives about the care and treatment options.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The feedback from the Friends and Family Test was positive for all wards even though the response rate was low. For example, the following wards achieved poor response rate; wards 5B (37%), 7B (28%), 11B (38%) and Swift ward (39%). However, all wards achieved over 90% for patients recommending the service.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through planning, design and delivery of service. Services were planned in a way which ensured flexibility and choice. For example, pre-operative assessment appointments were flexible. The service had increased their service to Saturday morning to meet the needs of patients. There was a clear criterion for staff to follow with patients being referred for an anaesthetic review as required.

The trust informed us that they currently did not have any involvement of people with learning disabilities or autism in the co-design of services. The patient experience committee did not have anyone with a learning disability or autism on their panel, but meetings were attended by the learning disability nurses. *(Source P80).*

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All staff we spoke with understood the importance of ensuring patients were segregated according to their gender. They explained the processes should there be a potential breach which included the completion of an incident report.

Facilities and premises were appropriate for the services being delivered. Surgical services were provided in an environment which was suitable for patients' needs. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections. Bathrooms and toilets were designated as single sex and were mostly sited within single sex bays. The service was compliant with Department of Health guidance on single sex accommodation.

The service provided a minor operations department which was situated in the out-patients area of ward 11B. This ensured all patients who required surgical intervention within this department were cared for in a safe and informed environment.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff confirmed they could contact the Rapid, Assessment, Interface and Discharge (RAID) team when required for advice and support. The RAID team is a mental health service which specialises in understanding the link between a patient's physical and mental health. We saw referrals in two records seen and observed that the RAID team had responded in a timely manner.

The service had systems to help care for patients in need of additional support or specialist intervention. The trust screened all patients over 75 years using the Rockwood frailty scale which was a tool used to assess frailty. This information was held on the trust’s electronic system. There was also an identification forget me not symbol in use for patients with a known diagnosis of dementia. This meant that the service had knowledge of each patient and what support staff could provide to meet their individual needs. Adjustments were made for patients living with a physical disability, which included wheelchair access, patient moving and handling equipment and facilities for bathing. The main hospital had disabled access and lifts in the main reception areas. The wards were open to visitors most of the day.
The service was able to request the support of staff for a “specialling” service. Specialling requires the constant attendance of a professional staff member on a patient with particular needs, for example if they were very confused, to protect them from harming themselves or others and to observe their behaviour. We saw this in place during the inspection. However, staff said that these staff were not always available when needed and that they flexed staff within the ward, to ensure patients were appropriately supported when the service was unavailable.

Managers monitored and acted to minimise missed appointments. The information team provided data for forthcoming appointments and admissions to outpatient teams, the bed management team and divisional leads. This meant they could plan appointments and make the required reasonable adjustments to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted. Staff informed us that when a patient did not attend an appointment, they liaised with the patient’s consultant and requested an update as to the urgency of the appointment. This meant that staff were fully informed prior to contacting the patient to make the relevant re-arrangements.

The service relieved pressure on other departments when they could treat patients in a day. The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds and to discharge patient’s home in a timely way. The hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community team to improve discharge arrangements. The service worked alongside local social services to facilitate timely and appropriate discharges for those patients requiring complex social care packages in the community. We observed discharges were discussed in the daily multidisciplinary meetings.

**Meeting people’s individual needs**

**The service was inclusive and took account of patients’ individual needs and preferences.**

**Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had processes and procedures in place which showed they made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or complex needs could access highly personalised care and achieve equality of outcomes. For example, patients with particular special needs, had a purple folder and there was a dedicated learning disability nurse for staff to contact for support. However, there was no hearing loop on the wards.

Wards were designed to meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff confirmed that they encouraged patients to bring in their patient passports when attending the hospital as this enabled them to support the daily needs of the patient. Staff also said that they tried to use the “This is me” document for patients living with dementia but said that completing the document was difficult as it was often dependent on family members providing them with the information. We did not see any completed “This is me” documentation in the records reviewed for those patients with a diagnosis of dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to guide us to the learning disability policy and the documentation relevant to the patient’s individual care pathways. Documents seen clearly
identified the sensory needs of patients which included for example the use of hearing aids and spectacles.

The service did not have information leaflets available in languages spoken by the patients and local community other than English. Staff informed us they could obtain information leaflets in other languages upon request.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that the requirement for an interpreter was usually flagged at their outpatient appointment so that when they reached the surgical pre-operative assessment clinic an interpreter was already booked. Staff said they used a face to face interpreter for pre-operative assessment wherever possible and if the need for an interpreter had not previously been identified, they would re-arrange the appointment where possible to enable an interpreter to be booked. A telephone interpretation service was also available, however, face to face interpreters were used on the day of surgery, for consent and for pre-operative assessments. Staff told us they did not normally use family members to interpret. This was in accordance with good practice.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Wards had long periods of time when they were open to visitors, usually from 9am to 9pm. Staff said they encouraged family members to support the patients with their food and drink during mealtimes. Housekeeping staff said they were informed daily of the patient’s individual food and drink preferences so that they could meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment. Wards had picture communication books to aid communication. The learning disability nurses could also provide easy read information. The hospital had carers policies in place to support carers or family members staying with the patient during their hospital admission if needed.

**Access and flow**

*People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.*

Managers monitored waiting times but did not always make sure patients could access services when needed and received treatment within agreed timeframes and national targets. We saw the theatre utilisation figures for June 2019. The surgery division accountability review meeting (ARM) report for June 2019 acknowledged that progress had not been carried out as quickly as desired. We saw that delays to patients going to the wards was identified on the theatre 100-day workplan with identified areas for review which included: performance, patient pathways and processes and the impact on theatre utilisation identified. Senior staff confirmed that they worked closely with the wards and bed management to try and reduce the effect on theatre lists. For example, the theatre dashboard showed the performance of theatre sessions.
The theatre utilisation reviewed and outlined the performance and recommendation which included:

- Acknowledged progress had not been as quick as desired.
- New 100-day plan in process of being agreed and presented back to the financial performance committee.
- Change to the way of working within theatres and to look at utilisation and delays with worse offenders for late starts to be actioned by the chairs.

We saw the audit analysis for theatre recovery delays (treatment centre). The audit aimed to capture all delays that occurred in the treatment centre recovery area. The audit seen was from June to August 2019. During this time, 2,671 patients underwent procedures of which 130 (4.8%) were delayed of more than or equal to 30 minutes. The average time of delay for this time was one hour 50 minutes. Common themes identified were:

- Receiving ward delays with the following identified – awaiting equipment such as pressure mattresses, staffing capacity issues, bed occupancy availability and delays to bed space cleaning requirements.
- Post anaesthesia care unit (PACU) – availability of space for transfer to ongoing care pre-discharge home.

The audit identified the next steps to take. Examples included:

- Adopt an audit for main theatres to ascertain a baseline
- Work alongside the site team, bed management and clinical leads to undertake a deep dive or themes raised
- Report and share progress through monthly theatre board

Staff informed us that the shortages of beds for surgical patients was having an impact on the service. Patients were being held in recovery daily and this was detrimental to the theatre listing resulting in surgical lists being delayed or cancelled. During the inspection, we observed this practice in progress with patients remaining in recovery waiting for a bed within the treatment centre and the post-anaesthetic care unit. Staff informed us that trust guidance required patients to be wheeled on a trolley accompanied by a qualified recovery nurse. We noted this journey took about 15 minutes as it was at the opposite end of the hospital. We also observed a child being recovered next to an adult and a further two children being recovered in adult beds.

The service used the 6-4-2 rules and responsibilities to ensure a smooth flow of theatre lists. The aim of the 6-4-2 rule is to:

- Notify all leave with six-weeks’ notice and communicate cover arrangements.
- Confirm with the waiting list office all booked patients.
- Once the list was complete, identify any changes to the order and confirm sign off through email to the waiting list coordinator.

Theatre staff confirmed they abided by this rule and we did not find any issues or concerns during the inspection. (Source: DR119)
Managers and staff worked to make sure patients did not stay longer than they needed to.

**Average length of stay**

**Elective Average Length of Stay - Lister Hospital**

![Bar chart showing elective average length of stay for different specialties at Lister Hospital and comparison with England average.]

*Note: Top three specialties for specific site based on count of activity.*

- From February 2018 to January 2019 the average length of stay for patients having elective surgery at Lister Hospital was 3.3 days. The average for England was 3.9 days.
- The average length of stay for patients having elective trauma and orthopaedic surgery at Lister Hospital was 3.3 days. The average for England was 3.7 days.
- The average length of stay for patients having elective urology surgery at Lister Hospital was 2.6 days. The average for England was 2.5 days.
- The average length of stay for patients having elective general surgery at Lister Hospital was 4.8 days. The average for England was 3.9 days.

**Non-Elective Average Length of Stay - Lister Hospital**

![Bar chart showing non-elective average length of stay for different specialties at Lister Hospital and comparison with England average.]

*Note: Top three specialties for specific site based on count of activity.*

- From February 2018 to January 2019 the average length of stay for patients having non-elective surgery at Lister Hospital was 3.4 days. The average for England was 4.7 days.
- The average length of stay for patients having non-elective general surgery at Lister Hospital was 3.4 days. The average for England was 3.7 days.
- The average length of stay for patients having non-elective plastic surgery at Lister Hospital was 0.8 days. The average for England was 1.5 days.
- The average length of stay for patients having non-elective trauma and orthopaedic surgery at Lister Hospital was 7.8 days. The average for England was 8.4 days.

*(Source: Hospital Episode Statistics)*

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.
Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2018 to April 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. The trust did not submit data to NHS England in the period from May 2018 to September 2018.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Five specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>84.8%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>84.1%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>78.2%</td>
<td>63.9%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>76.9%</td>
<td>60.2%</td>
</tr>
<tr>
<td>General surgery</td>
<td>72.6%</td>
<td>71.9%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>54.8%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>20.1%</td>
<td>56.4%</td>
</tr>
</tbody>
</table>

We saw a copy of the trust-wide standard operating procedure (SOP) for clinical harm reviews (referral to treatment 52 week waits on 18-week pathway). The SOP outlined the standard process, using patient tracking lists (PTLs) to identify breaches daily. Any patient who had breached their waiting time, or where the clock stopped was deemed incorrect, was recorded on the divisional 52-week tracker spreadsheets. (Source DR106). Divisional leads informed us that validation was now systematically being done and booking of patients being monitored. However, urology and cancer RTT remained an issue due to the capacity of the robot used for this type of surgery.

The trust had undertaken a clinical harm review process to provide assurance that there was divisional and executive oversight of potential or actual harm as an unintended consequence of;
delayed cancer treatment over 100 days, breaches of referral over 52 weeks and discharge summary delays. Senior staff informed us that they currently did not have any patients waiting over 52 weeks.

**Referral to Treatment figures for July 2019**

<table>
<thead>
<tr>
<th></th>
<th>9 July 2019</th>
<th>16 July 2019</th>
<th>30 July 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SURGERY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Backlog</td>
<td>4,004</td>
<td>4,136</td>
<td>4,110</td>
</tr>
<tr>
<td>Performance</td>
<td>84.36%</td>
<td>84.06%</td>
<td>84.10%</td>
</tr>
<tr>
<td><strong>Trauma &amp; Orthopaedic</strong></td>
<td>809</td>
<td>849</td>
<td>806</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>77.97%</td>
<td>77.23%</td>
<td>77.83%</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td>177</td>
<td>202</td>
<td>208</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>91.84%</td>
<td>90.80%</td>
<td>90.85%</td>
</tr>
<tr>
<td><strong>Ear, Nose &amp; Throat</strong></td>
<td>220</td>
<td>213</td>
<td>217</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>91.19%</td>
<td>91.82%</td>
<td>91.77%</td>
</tr>
<tr>
<td><strong>General surgery</strong></td>
<td>956</td>
<td>413</td>
<td>387</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>89.25%</td>
<td>87.82%</td>
<td>88.80%</td>
</tr>
<tr>
<td><strong>Gastroenterology</strong></td>
<td>624</td>
<td>649</td>
<td>698</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>81.16%</td>
<td>80.08%</td>
<td>78.31%</td>
</tr>
<tr>
<td><strong>Oral/Maxilla Facial</strong></td>
<td>640</td>
<td>618</td>
<td>652</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>73.35%</td>
<td>74.73%</td>
<td>71.56%</td>
</tr>
<tr>
<td><strong>Plastics</strong></td>
<td>215</td>
<td>213</td>
<td>194</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>88.94%</td>
<td>89.23%</td>
<td>90.03%</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>541</td>
<td>544</td>
<td>505</td>
</tr>
<tr>
<td>Backlog</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>88.62%</td>
<td>88.64%</td>
<td>89.16%</td>
</tr>
</tbody>
</table>

(Source: DR106 provided by the trust)

**Surgical division cancer figures for July 2019**

<table>
<thead>
<tr>
<th>Tumour type</th>
<th>June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour type</td>
<td>Target</td>
</tr>
<tr>
<td>Breast</td>
<td>85%</td>
</tr>
<tr>
<td>Haematological</td>
<td>85%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>85%</td>
</tr>
<tr>
<td>Lower Gastrointestinal</td>
<td>85%</td>
</tr>
<tr>
<td>Lung</td>
<td>85%</td>
</tr>
<tr>
<td>Skin</td>
<td>85%</td>
</tr>
<tr>
<td>Upper Gastrointestinal</td>
<td>85%</td>
</tr>
<tr>
<td>Urological</td>
<td>85%</td>
</tr>
</tbody>
</table>

(Source: Surgery division Accountability Review Meeting report – June 2019)

Senior staff informed us that the current position for cancer was to maintain a regular and sustained performance of the cancer standards. The cancer waiting times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated. The service had systems and processes to review their cancer waits daily and were flexing their surgical lists to meet the 62-day target. Senior staff confirmed this continued to be a work in progress.

**Cancelled operations**

Managers worked to keep the number of cancelled operations to a minimum. When patients had their treatment cancelled at the last minute, managers did not always make sure they were rearranged as soon as possible and within national targets and guidance. The service had created an action plan to oversee the rebooking of cancelled operations. Areas covered included:

- Review and update cancelled operations policy to reduce the number of clinical and non-clinical cancellations.
- Ensure staff understood differences between the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications for recording purposes. NCEPOD assists in
maintaining and improving standards of medical and surgical care for the benefit of the public.

- Weekly meeting to review all cancellations attended by theatres staff, waiting list and pre-operative assessment.

The actions were identified as having been completed in January and February 2019. The action plan did not identify the outcomes taken to manage the action which meant that it was difficult to ascertain what had been implemented to manage the risk. However, we saw a copy of the escalation policy for elective operation cancellations which was in date and had been updated March 2019. (Source: DR105).

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.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - East and North Hertfordshire NHS Trust**

![Graph showing the percentage of patients whose operation was cancelled and were not treated within 28 days from Q1 2017/18 to Q4 2018/19.](image)

From April 2017 to March 2019, the percentage of cancelled operations at the trust has generally been higher than the England average, with the percentage being higher in all quarters other than in Q3 2018/19. In the most recent period (Q4 2018/19), the trust cancelled 171 surgeries. Of these 16% weren’t treated within 28 days.

**Cancelled Operations as a percentage of elective admissions - East and North Hertfordshire NHS Trust**

![Graph showing the percentage of cancelled operations as a percentage of elective admissions from Q1 2017/18 to Q4 2018/19.](image)

The percentage of cancelled operations as a percentage of elective admissions at the trust has generally been in decline with a downward trend from Q1 2017/18 to Q1 2018/19. The percentage of cancelled operations at the trust has been similar or better than the England average from Q3 2017/19 to Q4 2018/19. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)
Patient moving wards per admission
Managers monitored that patient moves between ward were kept to a minimum. Patients were only moved when there was a clear medical reason or in their best interest.

From April 2018 to March 2019, within surgical wards at the trust, 98.6% of individuals did not move wards during their admission and 1.4% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night
Staff did not move patients between wards at night.

The trust has stated that this information has been formally captured from 21 January 2019. The trust reported that at the time of PIR submission there had been no ward moves at night.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers and staff worked to make sure that they started discharge planning as early as possible. The NHS standard contract requirements state that “following inpatient or day case care or an emergency department attendance, to issue a discharge summary to the patient’s GP within 24 hours.” This allowed GPs time to manage care effectively following departure from hospital. The trust informed us a backlog of summaries not sent to GPs became apparent in early 2018. The quality and safety report for April 2019 identified that 7,157 discharge summaries remained outstanding and efforts were being undertaken to reduce this number as soon as possible. When discharge summaries are not sent to the GP instructions for future care or treatment is not shared. This meant that patients could come to harm as a result. A review was undertaken of a sample of 1,595 patient notes discharged before July 2018 with no harm being identified. We saw the risk of continuing delays in the timely completion and distribution of discharge summaries was included on the trust risk register (6114).

We saw the surgical inpatient documentation audit which showed that only 60% of records had discharge information recorded 48 hours before discharge of the patient going home. During the inspection, we found that none of the records seen evidenced any discharge pre-planning. Staff informed us they usually updated the documents once the patient was discharged which we observed during the inspection. (Source: DR134)

The risk register acknowledged and recorded the actions undertaken which meant there were processes and procedures in place to review and manage risk. The accountability review meeting (ARM) report for June 2019 for the surgical division identified that there were currently over 2,000 missing discharge summaries under review. The report identified that issues remained with the audit showing that discharge summaries were being put against the wrong date with 1,000 attributed to the surgical assessment unit (SAU). The division was liaising with the director for quality about resolving this. This had been captured on the discharge summary remedial action plan. This outlined the actions for the surgical division which included daily monitoring while ensuring that high risk areas had specific support to complete and distribute discharge summaries. The plan identified that junior doctor rotation was now in place across SAU, general surgery and urology, which were considered high-risk areas. A ward clerk was in post, providing administration cover in SAU for 6 days a week. (Source: DR106).
In January 2019 a revised discharge summary process was piloted with the intention to significantly reduce the time taken for summaries to be completed and sent on to the GP. This had been applied to all new discharge summaries. The roll-out started in March 2019 with a significant number being completed in time. The quality and safety meeting minutes for April 2019, showed that the surgery backlog performance with clinical harm review had improved.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. We attended a multidisciplinary daily quality meeting where patients who were to be discharged, were reviewed. Attendees included managers, discharge co-ordinators, therapists and as required social service staff. All meetings were recorded which enabled staff to review the decisions made together with directions regarding a patient’s estimated date of discharge.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them. The surgical assessment unit (SAU) was based on a 24-hour turnaround to support early discharge. However, during the inspection we observed some patients had been there for up to three days. Staff confirmed this was a regular occurrence and impacted on their day to day service and their ability to review patients arriving on the unit. For example; for July 2019 there had been a total of 81 patients remaining over 24 hours of which 31 related to general surgery and 25 to plastic surgery. (Source: DR115)

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. Staff said they worked with external agencies to ensure that patients were transferred appropriately between services. We found no issues or concerns during the inspection.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. During the inspection there were no surgical patients on non-surgical wards. Staff explained the process should this happen with these patients being seen by their doctor daily. We did however, observe medical patients on surgical wards during the inspection. Staff confirmed these patients were reviewed by their doctors daily during weekdays and only if deemed urgent at weekends.

Managers worked to minimise the number of surgical patients on non-surgical wards. Daily bed management meetings reviewed the location and requirements of surgical beds. Senior staff informed us they ensured all patients were directed to the correct ward to ensure continuity of care.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Trust level
Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with did not recall being provided with any information about what to do if they had a complaint. However, they told us they would speak to the person in charge of the ward or get in touch with the patient advice and liaison service (PALS).

The service clearly displayed information about how to raise a concern in patient areas. We found hospital information leaflets about raising concerns and complaints were available on the leaflet racks on most wards. These provided information encouraging people to make comments and to raise a concern. They described the complaints process, the availability of advocacy services and the PALS service. The leaflet also signposted people to the Parliamentary and Health Ombudsman and the CQC if they were not happy with the way their complaint was managed.

Staff understood the policy on complaints and knew how to handle them. They were able to tell us of action taken to improve the service because of complaints and feedback from patients. A ward manager told us they had received complaints from relatives about being kept in touch about plans of care when the patient was unable to explain themselves. This was taken on board and communication had been improved.

From April 2018 to March 2019 the trust received 109 complaints in relation to surgery at the trust (11.3% of total complaints received by the trust). The trust took an average of 51.2 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 35 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>71</td>
<td>65.1%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>22</td>
<td>20.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>11</td>
<td>10.1%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
<td>2.8%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>109</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From April 2018 to March 2019, there were nine compliments received for surgery at the trust (19.1% of all received trust wide). All of the compliments were received by Lister Hospital, with eight compliments relating to urology and one compliment relating to plastics.
The trust stated that compliments are received via the CEO office, these are responded and sent to the relevant areas by the CEO. They are then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust is currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

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

Managers investigated complaints and identified themes. The quality and safety committee meeting minutes for April 2019 identified that the complaints team had undertaken a 90-day improvement plan to improve the response to complaints. This was to identify bottle necks and relationships between the response rate and quality of complaint responses. The aim of the improvement plan was to achieve no more than 120 open complaints across all divisions. At the end of March 2019, the total number of formal complaints open across the trust was 213 of which 92 referred to the surgical division. It was noted that in March 2019, Ward 5A received six formal complaints, five of which related to the quality of care. (Source: P82 Quality and safety report April 2019).

The surgical division had been acknowledged as an area to prioritise and to reduce the time taken to provide quality responses. The surgical divisional team engaged well with the improvement plan and had made a significant reduction in the number of open complaints with 32 identified at the end of July 2019. We saw that four were overdue and the remaining 28 were in date.

Complaints November 2018 to July 2019

![Complaints Graph]

(Evidence Source: P12 Surgery accountability review meeting report (July 2019)

We saw that the service reviewed the themes of complaints which are set out below:
Complaint themes as at July 2019

(Evidence Source: P12 Surgery accountability review meeting report (July 2019)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw actions in place based on the concerns raised. Examples included: a review of the current service provision and plans for a doctor to be on duty to reduce the waiting time for a feed being given via percutaneous endoscopic gastrostomy (PEG). PEG is a procedure to place a feeding tube through the skin and into the stomach). Additional lines had been installed in the ophthalmology department and clinic letters amended to reflect changes with patients being encouraged to use the online system to cancel and rearrange appointments.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgery services were managed within the surgical division. The leadership team was a new team and said they were working together to review the divisions’ performance, the challenges they faced, and the actions needed to address those. We saw the team was committed and determined to drive forward improvements to the service and tackle issues. The divisional quality managers supported the divisional leadership team with the day to day management of the quality and safety agenda within the division.

Staff spoke about the new leadership team and how they felt confident and empowered with their ability to move the service forward. They expressed the hope that the current team would bring more stability and continuity of approach. Most of the staff we spoke with were very positive about the divisional leadership teams and felt they were credible, grounded and willing to face the challenges. However, staff within the surgical pre-assessment unit felt that they were often forgotten, worked alone and did not have much input from the management team.

Matrons were visible, supportive, and approachable. Staff told us that if their matron was away, another matron visited to check on issues and any support required. We observed the presence of
the matron on the surgical wards throughout the day. The ward managers confirmed the matrons had a detailed knowledge of the pressure on the wards and took prompt action to address any problems.

We spoke with ward managers, who were approachable and enthusiastic. Some of the ward managers were relatively new in post and were looking at initiatives to improve the quality of care. All staff we spoke with were very positive about the leadership of the ward managers.

Several members of the multi-disciplinary team praised the ward managers and how they had improved morale on the wards and the positive changes that had been made to improve patient care. Although ward managers were knowledgeable about the ward's performance against the trust priorities and the areas for improvement we did not see actions in place to manage any shortfall. For example, the nursing and midwifery quality indicators identified areas for concern such as hand hygiene and electronic observations completed within the defined timeframe, but we did not see what actions there were to manage this. However, when we raised issues with them, they responded to address them immediately.

Staff informed us that the surgical division produced a newsletter which provided them with up to date information. We saw the surgery clinical governance newsletter for June 2019 which outlined the risks within the service and the sharing of learning from an incident.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a quality strategy (2019-2024) which set out the trust's ambition for the five-year transformation plan. The vision of this strategy was to enable staff to work safely, by giving them the skills and authority to make changes that drive improvement for themselves and for their patients. Examples of the values within the strategy included:

- Striving for continuous improvement by continually learning in everything we do.
- Valuing everybody through a robust governance and improvement framework.
- Being open and honest with candid, supportive skills that ensure fair balance of accountability and kindness. (Source P78)

The quality transformation programme (QTP) supported the quality strategy. The QTP set out key priorities which were:

- Value the basics
- Quality governance and risk
- Keeping patients safe
- Improving patient experience

Staff we spoke with said they were aware of the values but struggled to describe the vision and strategy. However, they could guide us to posters and leaflets on display and knew how to obtain the information on the trust's electronic system. Divisional leaders reported monthly to the members of the board against progress on actions to achieve the key priorities.

The trust had a nursing, midwifery and allied health professional (AHP) strategy (2019-2024) which aligned itself with the trust strategy. The strategy had key aims which included; developing and strengthening leadership, optimising pathways, valuing people and ensuring quality and safety
and partnership working. Recognition for the ward team’s achievements and hard work were made through ward plaques, certificates and annual awards. For example, we saw certificates on display in the wards’ main corridors to ensure that the identification was noticeable and valued.

The trust had developed a patient and carers strategy that set out key ambitions and priorities on how to provide continuous improvement in how they cared for patients, carers and family members.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The quality strategy for 2019/2024 identified the trust’s cultural ambition to improve the quality of care being delivered. This included:

- Quality and compassion being at the centre of how the trust behaves and acts
- Staff being proud of the care they deliver
- All roles and purpose are clear
- Feedback given to staff and services is a continuous process
- Visibility of trust and leadership values through their actions and behaviours.
- Staff feeling empowered to deliver and improve performance in all areas
- Confidence to challenge and speak up in a safe and supportive climate.

Staff we spoke with said they were not aware of the quality strategy’s cultural element but said they were proud of the team they worked for and felt they were treated equally and there was no exclusion to different religions or sexual orientation. The trust had a workforce and race equality policy and had addressed any outstanding issues in an action plan. Equality training was a mandatory training requirement.

The service had access to the raising concerns policy (Freedom to Speak Up). The policy provided staff with the processes to raise concerns where staff felt matters needed to be brought to the attention at a high level of the organisation, or where they had raised a concern through the routine levels such as incident reporting, line management or through division/directorate) and felt this was not being dealt with appropriately. While staff within the surgical division were confident in raising concerns, and felt they would be acted upon, most staff were not able to tell us the name of the trust’s Freedom to Speak Up Guardian (FTSUG). However, staff said they would go on the trust intranet to obtain their contact details if required.

Since inception in 2015, there had been a total of 85 concerns reported. From April to June 2018 six concerns had been raised to the FTSUG. The trust did not provide a breakdown of the concerns, but it was noted these were spread across the divisions and corporate areas. Areas identified included; employment terms and conditions (23) and bullying and harassment (19). Staff we spoke with during the inspection said they were unaware of any cases of bullying or harassment and confirmed they would notify their line manager should this be identified within their teams. (Source: P103 – raising concerns report)

Governance
Leaders did not always operate effective governance processes throughout the service and with partner organisations, it did not always have a systematic approach to continually improve the quality of its services. However, they had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior staff said that the service had made significant progress around strengthening its governance and risk frameworks, and the reporting of safety and quality. This had been reflected in improved timeliness of serious incident investigations and submission to commissioning bodies.

Service leads attended quality improvement meetings which discussed and provided updates on audits, quality improvement projects, mortality and morbidity, and incidents. Senior staff informed us they cascaded relevant information to staff through team meetings, safety huddles and the monthly rolling half day.

The division’s accountability review meeting (ARM) report aimed to maintain oversight of the performance management of the division, providing a review of progress against targets. This meant that managers, clinicians and staff understood what was expected of them in ensuring the overall success of the service. However, during the inspection, we were not assured that managers were using this process to drive improvements and reviewing processes and systems effectively. For example, we did not see clear actions for areas identified as concern such as hand hygiene and medicine management.

We saw the surgery clinical governance group minutes for May, June and July 2019. Areas covered included serious incidents and risk. All actions were brought forward each month, but we noted this was a re-iteration of the previous action and we could not establish whether each item had been presented and discussions recorded with any actions or outcomes. This meant that there was a risk that the minutes were not an accurate reflection of the discussions held which may impact on the efficiency of the service.

Ward managers completed monthly nursing and midwifery quality indicators that were sent to their matrons. These provided monitoring of key quality and performance indicators. From these, matrons provided a report based on their wards which were discussed at divisional clinical governance meetings. However, we did not see what action was implemented to oversee areas of concern for example, hand hygiene and electronic observations completed within the agreed timeframe.

Each month (except January and August) all non-emergency activity was suspended for half a day to allow a significant proportion of team members to meet and to review their practices. This dedicated time offered an opportunity to review outcomes such as audit findings, care reviews and incident investigations, and where necessary to make plans for improvement.

Team meetings were held every three to four months. They were minuted and sent to staff who had been unable to attend. Topics discuss included; new starters and leavers, sickness levels, new paperwork/documentation, and issues with discharges and take home medicines.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. While they identified and escalated relevant risks and issues they did not identify actions to reduce their impact. There was no evidence the outcomes recorded, what mitigation actions had been completed or if the risk had reduced or increased. However, they had plans to cope with unexpected events.
The May 2019 quality transformation plan report identified that staff including the surgical team would review its performance based on the key priorities. This work was to be complimented by the launch of the trust clinical excellence framework in the summer of 2019. However, as this was a work in progress, we were unable to ascertain the effectiveness of the workstream. (Source: P78) Areas covered included:

1. Valuing the Basics
Surgery participated in the harm free care collaborative to view the key categories to reduce incidences of avoidable harms. This involved an annual review of clinical areas for improvement which included for example; medication errors, falls and pressure ulcer data.

A surgical service quality dashboard was to be introduced to drive ideas and test theories of where improvements could be made. A common theme already identified included the escalation of safety concerns to the site safety meetings following discussion and feedback from ward safety huddles. However, we did not see actions from the quality dashboard to drive improvement home. For example, we identified concerns with the management of medicines across the service.

2. Keeping our patients safe
The safer surgery collaborative clinicians currently met weekly and reported to the theatre board monthly. Work involved the mapping of current trust theatre practice against NHS England National Safety Standards for Invasive Procedures (NatSSIPs) (2015) policy, aligning processes such as prosthesis checking, site marking, ‘stop before you block,’ surgical counts, consent and team handovers. The NatSSIPs had a set of standards setting out the principles of safe practice and advised healthcare professionals on how they could implement best practice through for example; safety checks, education and training.

Learning from the surgical never events have included:
- Distractions and interruptions
- Team situation awareness
- Theatre etiquette/behaviours

During the inspection theatre staff we spoke with were unaware of the never events and could not describe what had been implemented to manage the risk. An annual plan was underway to develop team training which could be shared across key surgical checks. These were additionally demonstrated in a local surgical team video for sharing at local inductions.

3. Patient & Carer Experience
The complaints team had undertaken a 90-day improvement plan with the support of the quality governance team, to identify bottle necks and relationships between the response rate and quality of complaint responses. The surgical division had been identified as an area to prioritise and a test of change had been undertaken to reduce the length of time taken to provide quality responses. At the end of March 2019, the total number of complaints open across the trust was 213 of which 92 (43%) referred to the surgical division.

4. Governance and risk
The trust aimed to improve the infrastructure to drive strong governance which was a key priority for the transformation of quality. The team which included members of the surgical team had engaged in weekly improvement meetings to for example:
- Improve clinical governance oversight with clinical governance leads
- Review the collation and management of internal audit programmes.
- Recruit workforce to meet the challenge of divisional quality and safety management.
We observed that staff completed internal audits with oversight within the improvement meetings. We did not see evidence that the systems to manage performance were overseen effectively. We did not see outcomes to mitigate the actions or if the risk had reduced or increased.

The service maintained a divisional risk register which defined the severity and likelihood of risks causing harm to patients or staff. However, they did not document the measures to be taken to reduce risks. The surgical team were aware of their main risks which included equipment and staffing.

Mortality and morbidity review meetings were held monthly by specialities as part of the rolling half day. Senior clinical representatives from the surgical division also attended the trust’s mortality surveillance meeting. We saw from the minutes that timeliness, management and learning relating to individual patient care were discussed. All staff were invited to attend, and nursing staff said they found it very useful and it had increased their knowledge of different patient conditions. However, most staff said that they found it difficult to attend due to staff restrictions on the wards.

The trust had developed a weekly monitoring of the clinical harm review process throughout the trust that related to delays in discharge summaries, any cancer waits and for patients waiting more than 52 weeks for treatment. However, we did not see outcomes to identify how the service would measure improvement against the action plans.

The trust had a major incident plan which staff could access on the trust intranet. Managers told us there had not been any recent training or practice events to ensure staff were aware of their responsibilities. The trust had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions, which might disable services or require special arrangements to be put in place to allow them to continue.

**Information management**

The service collected data and analysed it, but we did not see action to improve it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a wide range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances. Each of the indicators was given an equal rating. The trust produced a monthly nursing and midwifery quality indicator for each division and speciality which listed performance. However, we did not see actions to improve the service where performance was worse than the trust target.

Most leaders we spoke with were new in post and had a good knowledge of performance and where further improvements were needed to address these. We did not see quality performance displayed on surgical wards. However, the wards had updated their notice boards with the staff on duty, and the number of falls or pressure ulcers which had occurred over the month. We also observed staff being informed of ward performance at daily huddles.

The trust had a data protection policy in place, which incorporated the Data Protection Act 1998; staff received training on information governance as part of their mandatory training. Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place, which ensured data was submitted to external providers as required, such as serious incidents.
Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff said that communication had improved and there was more engagement and ownership of the issues across all professional groups. From our observations during the inspection and our discussions with staff, we felt that whilst this was the case there were still a small number of individual clinicians who were not completely engaged with improving performance.

The nursing leadership used safety huddles as key ways of sharing important messages and regular meetings were held for staff to learn from each other and enable them to cascade the information.

A corporate quality engagement strategy had been in place from 2019 to 2024. This outlined the trust’s vision “proud to deliver high quality compassionate care to our community.”

Patients and relatives were given the opportunity to provide feedback through the friends and family test or on the internet using NHS Choices.

The surgical division had created a staff survey action plan based on the results of the staff survey. Areas covered included appraisals, quality of non-mandatory training, incidents, health and wellbeing, job satisfaction and violence, harassment and bullying. We saw the actions which included for example: increase on the ward training to include human factors training, development and mentoring for band 5 nursing staff, “#thankyouthursday” which included patients thank you and compliments published across the division. Additionally, staff focus groups were held to ascertain their views on ensuring a safe environment. The action plan had a target percentage and achieve by date. However, the plan did not identify if the target had been achieved or evidence what progress had been made against the outcomes which meant that we could not be assured of the divisional leads’ oversight to improve appraisal rates, staff experience and quality and development.

Learning, continuous improvement and innovation

While all staff were committed to continually learning and improving services we found inconsistencies in the continuous improvement of the service. Staff had a good understanding of quality improvement methods and the skills to use them but we did not find outcomes to measure these. Leaders encouraged innovation and participation in research.

At the last inspection in July 2018, we identified several areas where improvement was needed. At this inspection we found the following had not improved:

- We observed staff at all levels failing to comply with the trust’s infection, prevention and control policy, particularly regarding hand hygiene.
- Although the service monitored and recorded room and fridge temperatures, there was no evidence of processes in place to escalate concerns of incorrect temperatures. This meant we could not be assured that medicines stored had not degraded and were suitable for use.
- While we saw improvement in the administration of time critical medicines to patients we were not assured that there were processes in place for patients who were not on the ward when these medicines were due.
• The trust did not ensure staff consistently followed the trust’s standard operating procedure relating to controlled drugs (CDs).
• The trust did not have emergency call bells in all patient bays on surgical wards.
• Ward staff did not complete daily routine bed-space checks, which included checks of gas/tubing connection.
• The percentage of staff receiving an annual appraisal had not improved over the last 15 months.

However, we found the following improvements:

• All patient records seen and, where appropriate, had received a reassessment of their risk of developing venous thromboembolism (VTE) (blood clot).
• There were systems and processes in place to ensure equipment was suitable and had been tested, checked and calibrated.
• Hypoglycaemia boxes were regularly checked with no issues highlighted.
• Resuscitation equipment was checked daily in line with trust policy except for a resuscitation trolley in theatres.
• There was evidence of learning from incidents. However, we found incidences where incident forms had not been completed, which meant that we could not be assured that the divisional leads had true oversight of events on the wards.
• The service was aiming to reduce the number of never events. We saw that they had achieved 250 days since the last never event.
• Improvements in the number of staff completing mandatory training, although this required further improvement.
• Staff had received training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards with compliance just below the trust target of 90%.
• Staff competency records were in place to ensure they had received appropriate training on various equipment.

In addressing the implementation of harm reviews for patient waiting for over 52 weeks from referral to treatment the trust had explored the ways other organisations were dealing with the issue and learnt from this. Staff informed us that there were currently no 52-week wait patients across the surgical division as at July 2019.

Staff in the pre-operative assessment had visited other trusts to review their pre-operative assessment pathway and processes to explore ways of further improving the service.

Senior staff had implemented the 100-day theatre transformation plan with identified areas for review which included: performance, patient pathways and processes.
Critical care at the Lister hospital is a 20 bedded unit divided into three areas; north, central and south. Each bed space can admit level three patients and there is capacity for up to 14 level three patients. Additionally, there are two side rooms in north and four in central.

The trust has a critical care outreach service that triages acute admissions, works collaboratively with the critical care team on safe transfers of patients and reviews all discharges on the wards post critical care.

The critical care unit (CCU) is staffed with 1:1 nursing for level three patients and 1:2 for level two patients. There is a nurse in charge for each area and an overall nurse co-ordinator. There are two consultants on during the day (as well as one consultant for outreach). The unit is supported by allied health professionals such as dieticians, physiotherapy, occupational therapist and pharmacists.

(Source: Trust Routine Provider Request – Context acute)

Levels of Critical Care:
- Level One - Acute ward care with additional support from the outreach team.
- Level Two - Detailed observation or intervention for example post-operative patients, patients with a single failing organ system.
- Level Three - Advanced respiratory support.

The CCU cares for patients from multiple specialities including:
- Continuous veno-venous hemofiltration and therapeutic plasma exchange.
- Complex medical and surgical patients.
- Vascular surgery/ obstetric/ trauma patients.
- Complex cardiac care

The trust has 28 critical care beds in total. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, East and North Hertfordshire NHS Trust and England.

This trust

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>35.7%</td>
</tr>
<tr>
<td>Adult</td>
<td>64.3%</td>
</tr>
</tbody>
</table>

England

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>24.5%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>5.5%</td>
</tr>
<tr>
<td>Adult</td>
<td>70.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

During the inspection, we spoke with 23 staff of various grades, including consultants, matrons clinical leads, unit sisters, critical care nurses, outreach nurses, ward clerks, care support staff...
workers, therapists and housekeepers. We spoke with two patients and their families and observed care and treatment. We looked at 12 patients’ medical records and 10 medication charts.

The service was last inspected in March 2016. At that inspection, the critical care service was rated good for the safe, effective, caring and responsive key lines of enquiry, whilst well-led was rated requires improvement. The overall rating for the service was good.

**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 made sure everyone completed it.

**Mandatory training completion rates**

**Nursing staff received and kept up to date with their mandatory training.** In critical care the 90% target was met for five of the eight mandatory training modules for which nursing staff were eligible. The target was almost met for a further two modules in equality and diversity and fire safety. Whilst data provided ahead of the inspection showed that nursing staff training for information governance was not at trust target, data seen on site showed that staff training levels now met trust target of 90%.

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

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>87</td>
<td>89</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>84</td>
<td>89</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>84</td>
<td>89</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>82</td>
<td>89</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control-Clinical (including management of inoculation injuries and hand hygiene) 2 year</td>
<td>81</td>
<td>89</td>
<td>91.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>80</td>
<td>89</td>
<td>89.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Note: The trust supplied no medical staffing data for critical care as this falls under the individual specialties.

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

Training data provided by the surgical division – July 2019.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention &amp; Control-Clinical (includes management of inoculation injuries &amp; hand hygiene) 2 Years</td>
<td>92.77%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>90.91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>90.91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>90.91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>89.16%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>89.16%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>87.50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>87.50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>87.50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>71.59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>70.45%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Surgery Division overall compliance</td>
<td>86.15%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Data requests DR38)

The mandatory training was comprehensive and met the needs of patients and staff. It covered core areas such as infection control, health and safety and moving and handling. Training was provided as online learning and face to face sessions. Staff told us that it was usually easy to access training.

Staff completed mandatory training in basic life support, intermediate life support, anaphylaxis training and sepsis recognition. Sepsis is a serious complication of an infection. Staff also received sepsis training which included the use of sepsis screening tools and the use of sepsis care bundles. All senior staff within the unit had completed advanced life support training. Compliance for sepsis training for staff within the CCU was 100%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The clinical education team for the unit monitored mandatory training and alerted staff when they needed to update their training. During our inspection we saw an up-to date training.
matrix in the staff rest room which also allowed staff to maintain their training modules. This included appraisal training and revalidation dates.

**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.

**Safeguarding training completion rates**

Nursing staff received training specific for their role on how to recognise and report abuse. Staff were trained to the appropriate level for safeguarding adults and children.

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

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>84</td>
<td>89</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>84</td>
<td>89</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>83</td>
<td>89</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>83</td>
<td>89</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In critical care the 90% target was met for all four of the safeguarding training modules for which qualified nursing staff were eligible.

Note: The trust supplied no medical staffing data for critical care as this falls under the individual specialities

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

Medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had an understanding of what harassment and discrimination was and knew the reporting processes.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust had policies on child sexual exploitation CSE and female genital mutilation (FGM). Information about CSE and FGM was disseminated to staff by safeguarding champions. These were nurses who had a particular interest in safeguarding and had close links with the safeguarding team. An up to date safeguarding policy supported staff to
protect people’s welfare.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff showed us how they could access safeguarding referral information on the trust intranet. The chief nurse was the named safeguarding adults lead.

Staff followed safe procedures for children visiting the unit. Staff we spoke with were aware of child safeguarding procedures which included children who were visiting the unit. During our inspection we saw staff following the correct process when making a referral, staff explained that if children came into the unit to visit relatives, a member of the play specialist team would be contacted for support and advice.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All units were clean and had suitable furnishings which were clean and well-maintained. All clinical areas we visited during the inspection including the dirty utility rooms and bed spaces were visibly clean and free from clutter. An external contractor provided cleaning services for the critical care environment. Staff told us that cleaning standards were regularly monitored through audits. There was a process to escalate concerns to the cleaning contract service.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were ‘arms bare below the elbows’ and wore personal protective equipment, as required, which was available throughout the unit. Trust policies were adhered to and staff wore minimal jewellery in line with the trust’s infection prevention and control (IPC) policy. Hand hygiene gels were available for use within the units and we observed all staff using alcohol hand gel.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was visibly clean, and most equipment had green “I am clean” stickers confirming the equipment had been cleaned within the last few days. However, during our inspection we saw that the arterial gas monitor input valve was contaminated with blood, we escalated this to the infection prevention nurse who explained it was usually cleaned after each use, however there was no record showing that this had been performed.

Consumable items were stored and sealed to prevent cross-contamination. All disposable equipment was in sealed bags in drawers or cupboards where possible, to prevent damage to packaging.

The service had side rooms available to isolate patients suspected of having an infection. This enabled staff to take extra precautions and help prevent the spread of infection. There were two side rooms in north unit and four in the central unit which were available for patients who required isolation. In critical care south, the bed spaces were larger and divided by a wall, which allowed for effective infection control precautions. During our inspection the unit’s newsletter discussed the use of PPE and understanding isolation specifically for the CCU.

There was a low rate of hospital-acquired infections. There had been no incidents of unit-acquired MRSA bacteraemia. There had been no incidences of Clostridium difficile between January 2018 to June 2019.

The unit followed manufacturer’s guidance when using the dialysis machines. We saw staff following effective handwashing practices and aseptic non-touch technique. Aseptic non-touch technique is a method designed to prevent contamination from bacteria.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment generally followed national guidance. However, not all bed spaces had a clinical hand wash basin. This was not in line with the Department of Health’s Health Building Note (HBN) 04-02 Critical care units. However, there were clinical hand wash basins in close proximity of all bed spaces. This meant that staff did not have to pass through bed spaces of other patients in the unit to wash their hands, which would have created an infection control risk. Core standards for critical care settings (GPICS) stated that critical care facilities should comply with national standards however, HBN compliance was not retrospective. We did not see any evidence of any safety issues whilst on inspection.

During our inspection we noted that patient moving equipment was stored in the main entrance corridor to CCU North. This meant that transferring patients into the unit could be difficult. Staff we spoke with said that it did not generally cause a problem when transferring patients in and out of the unit, however they were aware of the lack of space in which to move patient beds.

The CCU north adjoined to the theatre recovery department. We saw that theatre staff frequently passed through the unlocked door to use the kitchen and dirty utility room in the unit. The door was covered by a piece of disposable curtain that did not provide adequate privacy for the patients and there was no keypad system to prevent unauthorised entry. This was escalated during our inspection to the unit matron.

Staff carried out daily safety checks of specialist equipment. The unit had appropriate equipment for use in an emergency. There was a difficult airway intubation trolley divided into different trays according to the recommended intubation guidance. Intubation is the process of inserting a tube, through the mouth and then into the breathing passages. This is done so that a patient can have assistance with breathing. Resuscitation trolleys and equipment were standardised, and the contents were checked daily. There were resuscitation trolleys present in each of the CCU areas. Resuscitation trolleys had a tamper proof tag, which ensured staff that the trolley had not been used and the required equipment was available for emergency use. All emergency trolleys within the critical care areas had defibrillation machines and suction equipment present, which were checked and electronically tested in line with the trust policy.

The service had enough suitable equipment to help them to safely care for patients. Staff received training in equipment used across the service and the training and development team monitored completion of staff competencies on each piece of equipment. The CCU employed stores coordinators who ensured that all equipment was serviced and fit for purpose. Out of date or broken equipment was transferred to the hospital’s medical, biomedical and clinical engineering department (EMBE). The stores coordinators kept a log of the equipment to ensure traceability and monitoring of returned equipment which maintained the unit’s equipment levels.

Medicines and Healthcare Products Regulatory Agency (MHRA) medical device safety alerts were acted on appropriately. Medical device safety alerts is an alerting service which highlights concerns about specific medical devices and cascades and communicates information rapidly to hospitals.

The service had suitable facilities to meet the needs of patients’ families. There was a relatives’ room that was comfortably decorated. Water and toilets were available. During our inspection we
spoke with some relatives who said they found the room quiet and provided everything they needed.

Staff disposed of clinical waste safely. In all clinical areas, there was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. Sharps bins were stored out of patient areas but were accessible to staff. Lids were temporarily closed for safety and the bins were not overfull.

All the consumable stores we visited were well stocked. Staff described the stock rotation and ordering system. All consumables were stored appropriately and were within expiry date.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The unit used the National Early Warning Score 2 (NEWS 2) to highlight deterioration in patients and guide staff in the process of escalation of a deteriorating patient. Nurses recorded patient’s clinical observations in line with their clinical need requirement.

Staff recorded observations on specific charts that had been designed for critical care patients.

The critical care outreach team (CCOT) provided support 24 hours a day, seven days a week, 365 days a year. Outreach contributed to education, training and support. The team worked closely with critical care staff and acute ward staff, who reviewed patients on the ward, and made decisions about how best to support them.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Patients were seen a minimum of twice a day by the multi-disciplinary team, led by the consultant intensivist, where comprehensive treatment plans were documented. Staff followed national guidance and assessed and documented patient risk on admission and 24 hours later using evidence-based tools. This included Malnutrition Universal Screening Tool MUST assessment, venous thrombo-embolism (VTE), Waterlow, sedation tool and falls risk tools. During inspection, we reviewed 12 patient records and found that all necessary risk assessments had been completed in line with national guidance.

Staff knew about and dealt with any specific risk issues. Staff were highly knowledgeable regarding the care and support that patients receiving specialist care would require. Patients were monitored for different risk indicators. For example, sepsis, venous thromboembolism risk assessments and each ventilated patient was monitored using capnography. Capnography is the monitoring of the concentration of carbon dioxide on expiration. Such monitoring was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, (from the ventilator,) as well as during transfers and tracheostomy insertions.

The unit had been proactive in adapting their admissions processes to ensure that they were responding appropriately to patient risk. The unit prioritised patients for admission to critical care and worked to admit them within one hour. Patients that were deemed to be at higher risk of deterioration in the ward areas were cared for by a member of the CCOT team. The CCOT team oversaw care of the patient whilst arrangements for admission were made.
The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. The unit had access to mental health support based within the trust.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Daily handovers and safety huddles were undertaken on the unit. The huddle might include topics such as resuscitation status, infection risk, pressure ulcers, deteriorating patients, management of invasive lines, sedation and patients’ nutritional needs.

Following our last inspection in 2016, the staff had implemented a daily patient safety huddles which was completed by senior staff in the unit. This included the checking of patient bed spaces, ventilator pressures, patient identity bands and reviewed patient records.

The CCU had a discharge criteria checklist to ensure that all relevant information was handed over to the ward staff. Occasionally patients were discharged home from the unit, staff explained that letters to the general practitioners were appropriate and detailed when handing over patient care.

### Nurse staffing

The service planned to have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there was a high vacancy rate. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service planned to have enough nursing staff of all grades to keep patients safe. On inspection, we saw staffing boards displayed in the unit and we found that staffing levels were within recommended guidance. The unit maintained a one nurse to one patient ratio for level three patients and one nurse to two patients for level two patients. Senior supernumerary nurses (not providing hands on care during the shift) were available on each shift. Bank and agency staff were allocated shifts when staffing numbers required assistance.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. This was carried out in accordance with national guidance.

The unit clinical manager could adjust staffing levels daily according to the needs of patients. Senior nursing staff assessed the staffing number against the patient numbers and acuity for the next day’s shift. The unit used a social media tool to communicate with the nursing staff to promote additional staffing cover within the unit.

### Trust level

The table below shows a summary of the nursing staffing metrics in critical care at trust level compared to the trust’s targets, where applicable:
Critical care annual staffing metrics

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>105</td>
<td>-1%</td>
<td>25%</td>
<td>3.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>95</td>
<td>2%</td>
<td>24%</td>
<td>4.0%</td>
<td>10,931</td>
<td>742</td>
<td>9,052</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Vacancy rates

The service had a high nursing vacancy rate. Staff told us this was due to several factors, which included staff moving to more specialist roles within the hospital such as organ donation.

Monthly vacancy rates over the last 12 months for qualified nurses in critical care showed an upward trend from November 2018 to March 2019.

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

The service had taken mitigating actions. This included the use of bank and agency staff. Managers made sure all bank and agency staff had a full induction and understood the service. Posters had been placed around the trust to promote the unit and encourage ward staff to join the team.

During our inspection, the service displayed data which demonstrated that vacancy rates had improved since March 2019.
Turnover rates

Monthly turnover rates over the last 12 months for qualified nurses in critical care showed an upward trend from November 2018 to March 2019.

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses in critical care showed a shift from October 2018 to March 2019.

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

Bank staff usage
Monthly bank hours over the last 12 months for qualified nurses in critical care showed a shift from October 2018 to March 2019.

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

The service had high rates of bank and agency nurses on the units and managers requested staff that were familiar with the service. The unit had employed two agency staff on a block booking as staffing vacancies were so high. This meant those staff had greater familiarity and had a full induction which led to a comprehensive understanding of the unit.

Medical staffing

The service had access to enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

No medical staffing data is available as the trust does not have medical staff that fall directly under the critical care core service. Critical care medical staff are listed under anaesthetics (surgery) or other specialties.

The service had enough medical staff to keep patients safe. The Faculty of Intensive Care Medicine’s (FICM) Guidelines for the Provision of Intensive Care Services state that the resident medical trainee, specialty and associate specialist (SAS) doctor or an advanced critical care practitioner (ACCP) to patient ratio should not exceed one resident to eight patients. We reviewed staffing rotas which showed this standard had been achieved.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Managers could access locums when they needed additional medical staff, although they said that this was rarely required. Managers made sure locums had a full induction to the service before they started work. This included ensuring that they received an orientation to the unit and were trained in the electronic systems and equipment used on the unit.

The service always had a consultant on call during evenings and weekends. Consultants were scheduled to work on the unit from 8am to 6pm, Monday to Friday and 8am to 1pm on weekends. The service always had a consultant on call during evenings and weekends. All of records reviewed during our inspection, showed that a treatment plan was discussed with a consultant on a patient’s admission to critical care and that patients were reviewed in person by a consultant within 12 hours of admission.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Individual nursing and medical records were paper based and written and managed in a way that kept patients safe. Records were accurate, complete, legible and up-to-date. Risks to patients, for example falls, malnutrition and skin pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. Patient records were multidisciplinary, and we saw where entries had been made by nurses, doctors and allied health professionals.
including physiotherapists, occupational therapists, speech and language therapists and dietetic staff.

We reviewed 12 sets of nursing records and found them to be completed to a high standard. Daily care records, such as fluid balance sheets and medicine charts were stored in folders within the patient bed space. We looked at samples of daily care records, which were fully completed, legible with entries timed, dated and signed.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff had a checklist to ensure that all relevant information was included and up-to-date. This information was then transferred with the patient when they were discharged from the unit.

Records were stored securely. Patients’ paper notes were stored to ensure confidentiality and security. The notes were stored in trolleys and cabinets, which were closed and could also be locked for additional security. During our inspection we did not see any patient information unattended. Daily observation charts, medicine charts and patient pathway information was stored within the allocated bay trolley in the patient bed space. Staff in the unit ensured that all daily observation charts were covered when not in use this meant that confidentiality was maintained during relatives visiting.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff generally followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff had effective knowledge of safe medicines management and had access to the hospital’s medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines. A specialist critical care pharmacist was contacted if staff had concerns regarding medicines.

During our inspection we reviewed 10 medicine charts. We noted that three medicine charts showed there had been only one signatory documented following the administration of intravenous drugs. Recommended guidance from the Nursing and Midwifery Council suggests that medication should be checked by two clinical staff to ensure maximum safety is achieved. This was escalated at the time of our inspection, following this we noted that staff had been briefed in the morning huddle to ensure all medication is counter-signed.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Medicines were supplied and stored securely in all clinical areas. Medicines were stored in suitable locked cupboards within each area with only appropriate staff having access to the keys. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Medicines that required refrigeration were kept at the correct temperature and staff checked and mostly recorded the fridge temperatures daily. We saw that there were missing fridge temperatures on three occasions in the previous month. This was escalated during our inspection, although senior staff had been aware of this, the staff explained that hospital policy advised that if fridge temperatures had been missed on three occasion all medication should be discarded. However, the fridge temperature omissions had not been missed on consecutive days therefore it
did not warrant the medication being disposed of. This ensured that medicines that were
temperature sensitive were stored correctly.

Staff followed current national practice to check patients had the correct medicines. A pharmacist
visited the unit every weekday. They provided support with prescribing and use of medicines and
ensured there were appropriate stocks. The pharmacy team provided an on-call service which
guaranteed advice was always available.

The service had systems to ensure staff knew about safety alerts and incidents. Information about
medicines incidents were displayed on a staff information board.

Decision making processes were in place to ensure people’s behaviour was not controlled by
excessive and inappropriate use of medicines. In the records we reviewed we saw no patients
who were having their behaviour controlled by medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near
misses 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. Managers ensured
that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. The trust used an electronic
incident reporting system and staff we spoke with knew how to report them. Staff understood their
responsibilities to raise concerns and report internal incidents.

Staff reported all incidents that they should report. Staff gave examples of when they had to report
an incident or near miss, for example delayed patient discharges and equipment failure.

Staff said they received feedback from incidents raised and felt this was informative. Actions to
prevent incidents occurring again were identified and then shared. Staff were informed of changes
to practice via incident feedback, safety huddles and were present on the units notice board.

**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 had the potential to
cause serious patient harm or death but neither need have happened for an incident to be a
never event.

From June 2018 to May 2019, the trust reported no incidents that were classified as a never
event in critical care.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere in the trust.
Staff were able to give an example of a never event that had happened in surgery.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents
(SIs) in critical care which met the reporting criteria set by NHS England from June 2018 to May
2019.

(Source: Strategic Executive Information System (STEIS))
Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, a do not attempt resuscitation form was found in another patient's notes. The unit noted that this could have caused a delay in the patient receiving immediate treatment and implemented a check for staff to ensure that all patient information was pertinent to that patient.

During our inspection we saw evidence of learning from a previous never event. This included an educational newsletter designed for the staff. The learning outcomes and completed actions were included in the newsletter along with pictorial implementation to improve staff's understanding.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. The consultants and senior nursing team held open debriefing sessions following incidents that occurred on the unit. This meant that staff were able to openly contribute to the actions implemented and generated a no blame culture.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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 five new pressure ulcers, no falls with harm and no new catheter urinary tract infections from May 2018 to May 2019

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at East and North Hertfordshire NHS Trust

![Graph showing the prevalence rate of pressure ulcers from 2018 to 2019](image)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient’s subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Patients were assessed, and a plan of care put in place on admission. The service used a combination of national guidelines and policy to determine the care and treatment provided. The service followed NICE NG51 Sepsis: recognition, diagnosis and early management guidance and guidance from the National Institute for Health and Care Excellence (NICE), Intensive Care Society, the East of England critical care operational delivery network. There were regular audits to ensure compliance and the results were shared with staff.

The unit used evidence-based quality principles agreed by the East of England critical care network these included diagnostic testing, minimising sedation and antibiotic use in critical care. We observed patient records that demonstrated that the service was meeting the requirements of NICE guidance (CG83) which identified a need for an individualised, structured rehabilitation programme.

Staff told us they used a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. These included a urinary catheter pathway and guidance on the prevention of venous thrombo-embolism.

There was a wide range of information on best practice which was displayed in staff areas. This included hydration and fluid balance, safeguarding referrals and equality and diversity information.

The unit participated in organ-donation work for the trust. The trust had a clinical lead for organ donation and was supported by specialist nurses for organ donation. The trust was part of the UK national organ donation programme and followed National Institute for Health and Care Excellence (NICE) guideline CG135: Organ donation for transplantation.

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)
Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff followed guidance and protocol detailed in a Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) policy. The policy was based on up-to-date legislation as at the time of inspection visit. Staff were aware of their role under the Mental Health Act and ensured mental capacity assessments were carried out when a patient showed signs of lacking capacity.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff continually monitored the psychological and emotional needs of all patients and visitors to the ward to ensure they were coping with the information they had received, and to provide emotional support when needed. We observed a staff member interacting with a patient’s relative and ensuring the relative’s wellbeing was maintained.

**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 needs.

Staff made sure patients had support with nutrition and hydration to meet their needs. Patients were provided with water jugs, which were placed within reach. We observed staff offering drinks to patients and relatives at regular intervals. Procedures had been implemented to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Nursing staff monitored patients’ hydration and completed fluid balance charts. There were also nutrition charts for patients who were frail or at risk of malnutrition, these were completed each time the patient was offered food or drink and how much they had taken. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. The unit had dietetic support to support patients effectively. Staff followed the trust’s standard feeding protocols to ensure ventilated patients received adequate nutritional intake. This included the target rates for feeding according to the patient’s weight, nutrition and hydration. This meant that patients received appropriate nutrition to meet their needs.

Patient records we looked at confirmed that patients had been seen by a dietician, if necessary. We observed during our visit that dieticians visited the critical care units.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The unit used a standardised pain scoring tool which was suitable for patients who were unable to express pain. The pain assessment included a check on non-verbal responses, or changes to the patient’s observations.

Staff prescribed, administered and recorded all pain relief accurately. Patients received pain relief soon after it was identified they needed it, or they requested it. The records we reviewed evidenced that patients had regular pain relief. Patients we spoke with told us staff ensured they
had the pain relief they needed, and they were kept comfortable. Pain was managed with different protocols depending upon the patient’s treatment. For example, patients who were postoperative might have epidural pain management.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for patients.**

The service participated in all relevant national clinical audits. The service performed below the national standards in national clinical outcome audits. Managers in the unit had implemented processes to improve the trust performance. An admission, discharge and escalation policy had been implemented to improve patient flow through the hospital which was the main contributory cause of the unit not reaching some of the national standards.

They compared local results with those of other services to learn from them. The results of most national audits showed trust performance was generally in line with national averages. Action plans were in place where improvements were required.

**ICNARC Participation**

The trust contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 Annual Report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**ICNARC results**

**Lister Hospital – Intensive Care Unit**

The table below summarises performance at the for the Intensive Care Unit at Lister Hospital in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non-clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.4%</td>
<td>Within expected range</td>
<td>x</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>7.4%</td>
<td>Within expected range</td>
<td>x</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible)</td>
<td>3.7%</td>
<td>Not in the worst 5% of units</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| **Crude non-clinical transfers**  
*Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers* | 0.2% | Within expected range | ✗ |
| **Crude, non-delayed, out-of-hours discharge to the ward proportion**  
*Discharge out-of-hours is associated with increased risk of mortality* | 0.8% | Within expected range | ✗ |
| **Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)**  
*Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day* | 12.2% | Within the worst 5% of units | ✗ |
| **Risk-adjusted hospital mortality ratio (all patients)**  
*Risk-adjusted measures take into account the differences in the case-mix of patients treated* | 1.1 | Within expected range | No current standard |
| **Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients)**  
*Risk-adjusted measures take into account the differences in the case-mix of patients treated* | 0.9 | Within expected limits | No current standard |

**Lister Hospital – Respiratory High Dependency Unit**

The table below summarises performance at the for the Respiratory High Dependency Unit at Lister Hospital in the 2017/18 ICNARC Audit.
Managers carried out a comprehensive audit programme. This included both national and internal audits.

Managers used information from the audits to improve care and treatment. Local audit work that reflected national guidance was regularly undertaken. Staff told us that a calendar of audits was planned for which were assigned to staff such as hand hygiene, documentation and spontaneous breathing and assessment for extubating (removal of breathing tubes). Re-audits were undertaken to improve patient outcomes.

Improvement was checked and monitored. Action plans were present which evidenced improvement had been made.

Managers shared and made sure staff understood information from the audits. Senior staff within the unit facilitated discharge from the critical care unit. However, due to bed occupancy within the hospital discharges did not usually occur within four hours of decision to discharge being made.

**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 and development.*

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had received training in tasks appropriate to their role. We observed staff competencies were signed and dated appropriately. Staff told us they were proactively supported and encouraged to acquire new skills and use their transferable skills in the unit.

Managers gave all new staff a full induction tailored to their role before they started work. There were competency packages for all clinical and non-clinical staff to be completed.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed that they received an annual appraisal. In CCU, staff were separated into groups whereby the matron would perform the band seven reviews, band sevens would conduct an appraisal with band six staff, who in turn would conduct an appraisal for band five staff.

From April 2018 to March 2019, 80.8% of staff within critical care department at the trust received an appraisal compared to a trust target of 90%. However, during our inspection, we saw that as of July 2019, 92% of staff had received their appraisal reviews.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>3</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>56</td>
</tr>
</tbody>
</table>
Note: The trust supplied no medical staffing data for critical care as this falls under the individual specialties

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

There were enough clinical educators to support staff learning and development. There was a strong commitment to training and education within the unit. There was a clinical nurse educator team that comprised of four band six staff, each member of the team completed a day per week educators’ role which had been allocated into the rota. The education team said this worked well, as each member of the team brought new ideas and different skills to the unit.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. There was a programme of training and education and comprehensive workbooks and portfolios in relation to clinical and equipment competencies. These were checked and countersigned by the clinical nurse educators or assessors when staff had achieved the competence.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. The unit held monthly team meetings which were available for staff to read in the staff rest room. Subjects discussed within the meetings included recruitment, patient records, equipment and new implementations being actioned.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Competency days had been arranged throughout the year for all nursing staff in the unit. This included patient assessment, use of medical devices such as syringe drivers and epidural, VTE training and airway management. There were also advanced training days topics included respiratory, cardiovascular, renal and neurological competencies.

Nursing staff told us that they were supported by the unit to complete their revalidation. Revalidation is the process where registered personnel demonstrate that they remain fit to practice. Medical staff we spoke with were happy with their level of support and development opportunities that had been made available for them.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The unit supported the trusts practice assessors’ course which had been implemented instead of mentorship training.

Managers were in the process of making sure staff received any specialist training for their role. The number of nurses in possession of a post registration award in critical care nursing was not in line with national guidance. At the time of our inspection, 46% of registered nursing staff had completed a post registration critical care course, compared to the national standard of 50%, as set out in the Faculty of Intensive Care Medicine’s (FICM) Guidelines for the Provision of Intensive Care Services. However, six nurses were due to complete a post registration critical care course in September 2019, which would bring the unit in line with national guidance.

All clinical staff in the unit had achieved intermediate life support qualification, senior staff within the unit had completed their advanced life support course. This meant that all clinical staff had received the necessary resuscitation training required for a critical care unit.
Managers identified poor staff performance promptly and supported staff to improve. Band seven nurse and clinical nurse educators explained that if staff needed more supervision in developing skills, personal one-to-one training would be given to ensure standards had been achieved.

Managers recruited, trained and supported volunteers to support patients in the service. The trust supported ‘butterfly volunteers’, these volunteers provided support for patients and families during end of life care.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

Staff held regular multidisciplinary (MDT) meetings to discuss patients and improve their care. Effective multidisciplinary team working practices were in place. Relevant staff, teams and services were involved in assessing, planning and delivering patient’s care and treatment. They worked together to understand and meet the range and complexity of patients’ needs. This included pharmacists, physiotherapists, CCOT, and speech and language therapists.

The CCOT supported both admission and discharge from CCU. They reviewed patients that had escalated to level 1 care on the wards and stayed with the patients until they had de-escalated to level 0 care or were admitted to the CCU. They also reviewed patients deemed fit for discharge from CCU and supported transfers to the ward environment. They introduced themselves and explained the service they provided to the patients. They provided follow up and support to ward nursing staff and the patient until they were discharged home from the hospital.

Staff worked across health care disciplines and with other agencies when required to care for patients. Discussions and decisions at MDT meetings ensured clear decision making for patients. There was a clear rationale for the decisions which were referenced in the patients notes. Staff reported effective working relationships between all health care disciplines and we saw this during our inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were aware of the process for referring patient however, we saw no evidence of patients requiring this service at the time of our inspection.

**Seven-day services**

*Key services were available seven days a week to support timely patient care.*

Staff on wards could call for support from the critical care outreach team (CCOT) seven days a week. The outreach team had the same shift patterns as the critical care nurses on the ICCU. The outreach service ran 24 hours a day, seven days a week service.

This was in line with recommendations made in the FICM guidelines. We spoke with the CCOT who said they supported the CCU team when discharging patients from the unit to the ward areas. This provided patients the necessary care during their transition to the ward areas. The CCOT team were in the process of developing a more robust service in the hospital at night.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Consultants did twice daily ward rounds during the week. At weekends, consultant led ward rounds only took place once a day. The unit had access
to an intensivist who was available 24 hours a day, seven days a week. There was out of hour on-call intensivist cover for telephone consultations and who could access the hospital within 30 minutes if needed.

Access to speech and language therapist (SALT) to provide swallow assessments were not always possible during the weekends. This had been reviewed by the senior staff and training had been arranged to provide the skills necessary, to some nursing staff, to assess swallow reflexes for awake patients. At the time of our inspection training had been completed which meant that the unit had mitigated any risks caused from not having access to the SALT team out of hours.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every unit. Leaflets were available to patients and relatives. The CCU had a booklet for patients and relatives who were admitted to the unit which had been published by a charity. The booklet included information on how a critical illness can affect the body and how patients may feel after being in CCU.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Each patient was individually assessed to promote specific individualised care. For example, therapy staff would assess patients’ rehabilitation needs and where appropriate, patients were encouraged to get out of bed and to complete the rehabilitation exercises.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient’s consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients’ liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence including documentation where steps had been taken to involve a person in making decisions in advance of when they might lack capacity.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We saw evidence including documentation and clinic note entries where steps had been taken to involve a person in making decisions in advance of when they might lack capacity. Staff understood that any action they took on a patient’s behalf was to be done while being least restrictive of the person’s rights and freedom of action. We also saw a best interest flowchart which explained the necessary steps taken for a patient following admission to the unit.

Staff made sure patients consented to treatment based on all the information available. They provided patients with a detailed explanation of the condition they presented and the treatment options available. Patients confirmed they were able to give informed consent.

Staff clearly recorded consent in the patients’ records.

Mental Capacity Act and Deprivation of Liberty training completion
All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards in line with the trust’s target.

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act and Deprivation of Liberty Safeguards training. The trust stated that Mental Capacity Act and Deprivation of Liberty Safeguards training was delivered as part of the adult safeguarding module.

A breakdown of compliance for Mental Capacity Act and Deprivation of Liberty Safeguards training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>83</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>83</td>
</tr>
</tbody>
</table>

In critical care the target was met for both of the Mental Capacity Act and Deprivation of Liberty Safeguards training modules for which registered nurses were eligible.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the Trust’s target.

Note: The trust supplied no medical staffing data for critical care as this falls under the individual specialities

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff were knowledgeable about the process involved in applying for a Deprivation of Liberty Safeguards, although no patients were subject to one at the time of inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff described how they could access support and advice via the trust wide intranet.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty safeguards in line with approved documentation. None of the records we reviewed related to any patients who were subject to Deprivation of Liberty Safeguards.
Is the service caring?

Compassionate care

Staff consistently treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were always discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff followed policy to keep patient care and treatment confidential. We observed excellent attention from all staff to patients’ privacy and dignity. We saw curtains drawn around patients, doors or blinds closed in private rooms when necessary, and voices lowered to avoid confidential or private information being overheard. The nature of risk and ensuring patient safety in critical care units meant there was often reduced opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to considering privacy and dignity, cultural requirements or religious needs.

Care from the nursing staff, medical staff and allied health professionals such as physiotherapists was delivered with kindness, patience and warmth. Nurses talked quietly with patients and reassured them continually. We saw them holding the hands of patients while they spoke with them. The atmosphere was calm and professional, without losing warmth and reassurance for everyone concerned. All staff introduced themselves to patients and their visitors. Nurses were observed talking to patients and explaining what care they were delivering, even if the patient was not conscious. Staff kept this in mind, particularly with difficult conversations, these took place where possible away from the patient’s bedside.

Patients said staff treated them well and with kindness. Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Some feedback comments were visible in the coffee room for all staff to read, they included comments such as ‘nothing is considered too trivial’, ‘quiet respectful’, ‘efficient but calm’ and ‘couldn’t be faulted’. Innovative caring for patients, such as the development of patient diaries, was encouraged and valued.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our inspection the staff discussed the care of a mental health patient who was to be admitted, staff showed empathy and understanding to the patient’s required needs. There were nurses with link roles in matters relating to mental health, learning disabilities and dementia. The staff told us they all understood how being admitted to a critical care unit could often provoke anxiety in patients. Staff were acutely aware that some patients may need tailored support due to communication needs such as patients with mental health illness or cognitive impairments.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. People’s cultural and religious, social and personal needs were respected. This was particularly so with patients who were at the end of their life or had passed away. There was a bereavement team who gave advice and guidance for staff to provide appropriate and sensitive care.

Emotional support

Staff always provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.
Staff gave patients and those close to them help, emotional support and advice when they needed it. In the unit there was a strong patient centred culture, staff offered support in a caring, respectful and supportive manner. Staff recognised the needs of patients and relatives, when necessary staff referred patients to other services in the hospital such as the chaplaincy teams.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff pulled bedside curtains around the bed space when patients were distressed provided this did not cause the patient further upset. They also gave patients the comfort and reassurance to elevate distress quickly and effectively.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff we spoke with said they had received training in breaking bad news. We saw staff being empathetic and offered support when needed. During our inspection we observed a senior member of staff allowing time for the family to grieve, and when necessary offered assistance by providing comfort with a personal touch.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. The unit had implemented patient diaries. Staff explained that patients were likely to experience clinically significant symptoms of anxiety and depression following their discharge from hospital. The diary helped patients understand what had happened to them in the unit and provided an increased awareness of their emotions and how to cope with them. Staff said the diaries did not only fill the memory gap, but also provided a caring intervention, which promoted holistic nursing.

Nursing staff encouraged families and carers to come to the unit to provide emotional support. Families and carers were helped to overcome any of their own anxieties, so they could provide comfort to confused, scared or disorientated patients.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff consistently communicated with people so that they understood their care, treatment and condition. We saw staff explaining a treatment process to a patient. Staff recognised when patients and relatives needed additional support to help them understand and be involved in their care and treatment and enabled them to access this.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Relatives were approached with compassion when a patient was a possible eligible organ donor. Staff within the unit discussed organ donation. The staff showed their knowledge, experience and genuinely caring approach in this difficult subject.

Relatives of patients were kept informed and involved with decisions when appropriate. Staff said they were aware that the unit could be overwhelming for visitors, and therefore would give information as sensitively as possible. A doctor and a nurse mentioned how they would look for signs of anxiety or distress when delivering difficult news to relatives and make sure the person was supported.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The unit actively encouraged patients and relatives to provide feedback. The unit had a lessons learnt feedback system which encouraged patients and relatives
to give comments on excellent care and missed opportunities, this meant the unit could review all the comments and ensure that high standards of care had been given.

Staff supported patients to make advanced decisions about their care. The department had a strong focus upon bereavement and care in the last days of life. There was a link nurse for bereavement and the trust provided an end of life care service. The trust had produced a care plan to be used in the specific circumstances of a patient within the end of their life. Staff in the CCU used the enhanced care pathway and supported patients to make informed decisions about their care when appropriate.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Managers ensured that they understood the needs of the local population by gathering feedback from patients, relatives and staff. Critical care provision on the unit flexed to meet the differing needs of level two and level three patients.

During our inspection staff told us that due to the high number of vacancies experienced at the beginning of the year, the number of operational beds was reduced from 20 to 18. This meant that patient safety and staff well-being had been risk assessed and actions were mitigated. At the time of our inspection the unit had reduced the amount of non-staffed beds to two, which had been attributed to an improvement in the workforce.

There was a good response from consultants when new patients were admitted. The shift patterns were established so all patients were seen by a consultant intensivist within 12 hours of admission.

The critical care outreach team reviewed all patients on the wards who were discharged from intensive care. Patients who had been on the unit were seen until they were discharged from hospital.

Patients who were discharged from CCU did not have access to any follow up clinic as recommended by the FICU. The unit was in the process of submitting a business case to provide a follow up appointment system. The nursing team provided all CCU patients with a booklet with support frameworks and guidance in relation to patients physical and psychological problems.

The hospital had the ability to temporarily increase its capacity to care for critically ill patients in extreme circumstances. This would involve using the recovery unit in theatre, where staff were trained in caring for critically ill patients and would be supported by the critical care team. However, senior staff told us that this was very infrequent.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. They were knowledgeable about the circumstances around a justified breach and an unjustified breach of mixed sex accommodation within critical care. Staff tried to ensure they did not breach mixed sex accommodation standards when patients were deemed medically fit for discharge by moving patients to other areas on the unit.
Facilities and premises were appropriate for the services being delivered. The environment in the unit was designed to meet patients’ and visitors’ needs. As recommended by the Department of Health, there were separate entrances for visitors and patients. There was an intercom and CCTV at the main entrance.

Staff were able to see patients in the open bed space areas, and patients in the side rooms in the unit were supported by and visible to staff working in the immediate area. Side rooms were, as recommended, square or rectangular, and not L-shaped, where visibility could be reduced.

There was a large visitor’s room with comfortable seating and a television. There were tea and coffee making facilities and a variety of snacks available for visitors to use. There was a further visitor’s room which provided a quiet and private space.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. For patients with learning disabilities, staff told us they received information and documentation from families and carers. During our inspection, we saw that a patient with mental health needs had been allocated a side room to provide a quiet area. Carers were present during the patient’s admission and were advised on the values and processes within the unit. This ensured that all the health care teams worked together in providing a supportive and calm environment.

The units had not been specifically designed to meet the needs of patients living with dementia. However, staff made adjustments to meet individual needs and all patient bays were visible. During our inspection staff said that adaptations were made when caring for dementia or patients with a learning disability. Carers were encouraged to bring familiar belongings into the unit, to provide a more suitable environment.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff could refer patients to relevant specialist teams such as the mental health liaison team, learning disabilities specialist nurse or specialist dementia nurses.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service did not have information leaflets available in languages spoken by the patients and local community. However, staff had access to a translation service and could book translators for use over the telephone and face to face.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.
Access and flow

People could access the service when they needed it and received the right care promptly. The unit admitted, treated and discharged patients and were generally in line with national standards.

Despite issues with access and flow due to bed pressures in the hospital, the CCU was responsive to emergency admissions.

Bed occupancy

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers in the service requested additional bed meetings if capacity on the unit was low. Patients having surgery came straight from theatre to the unit, there were no patients being cared for in theatre recovery areas during our inspection because there were no beds in critical care.

Emergency patients from the accident and emergency (A&E) department were prioritised for admission, followed by emergency admissions from other wards in the hospital. Managers collected data on the time to admit a patient from the time of decision to admit from the A&E department.

From May 2018 to April 2019, East and North Hertfordshire NHS Trust had seen adult bed occupancy fluctuate above and below the England average. The critical care bed occupancy was higher than the England in all months other than December 2018 in the period from October 2018 to April 2019.

Adult critical care Bed occupancy rates, East and North Hertfordshire NHS Trust.

(Source: NHS England)

Managers and staff worked to make sure patients did not stay longer than they needed to, however, this was not always achieved. The unit had a department policy outlining the required process to facilitate transfers within the hospital. However, due to the lack of patient beds within the trust this was not always possible.

Patients that were medically fit to be transferred were identified by the unit. Staff informed the hospital site team who would then enable the transfer. Staff told us that often planned discharges to one of the wards could not take place, as beds were sometimes not available. During our inspection a patient had been waiting three days to be discharged to the ward.

The unit’s policy stated that ‘transfer of step-down patients should not occur between 20:00 and 07:00 hours if at all avoidable as recommended by Guidelines for the Provision of Intensive Care Services 2015 (GPICS)’. The unit generally maintained this standard, however, on occasion
transfers did occur during these hours. The clinical team in the unit would assess the suitability of transferring the patient and decide as to whether to proceed with the patient move.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured that patients discharged with complex mental health needs had appropriate assessments by a multi-disciplinary mental health crisis team and had appropriate care arranged for the patient in the community. Outreach staff were involved in ensuring discharges from the CCU were seamless and ensured all equipment and care needs were available for patients in the community before they were discharged from the hospital.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The critical care matron had worked to raise the profile for critical care discharges at bed meetings and ensure that these had the same profile as discharges from other areas. The matron had also worked to ensure that there was a good relationship with the site team to help facilitate discharges.

Staff supported patients when they were referred or transferred between services. The outreach team went with patients when they were transferred from the CCU to other areas within the hospital. They supported the patient and staff on the wards to ensure the patients’ care and treatment plans were going well and to pick up any changes in the patients’ conditions.

A post critical care booklet was given to the patient or relatives explaining the next steps in the patients’ recovery. There was a patient diary and rehabilitation plan specific for each patient transfer of discharge to support the patients transfer.

Prior to transfer to the ward, CCU staff liaised with the receiving ward. Ensuring that all necessary equipment or specific drugs needed by the ward were available.

Managers monitored patient transfers and followed national standards. A transfer plan was documented in the patients notes in accordance with NICE Guidance CG83. It included a summary of critical care stay including diagnosis and treatment, any unresolved issues and ongoing treatment plans which included medication, therapies and nutrition.

The unit had no non-clinical transfers in the previous 12-month period. A non-clinical transfer is a transfer from the critical care unit for capacity issues rather than for clinical need.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns. Staff told us that they would attempt to resolve any complaints or concerns informally in the first instance and would then escalate to a more senior member of staff or to the Patient Advice and Liaison Service.

The service clearly displayed information about how to raise a concern in patient areas. Posters detailing how to make a complaint were displayed on the unit and throughout the trust.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers, after the investigation into their complaint. Staff knew how to support patients and their families if they wished to complain. Staff referred to the complaints policy on the trust intranet.
Managers investigated complaints and identified themes. Staff told us complaints and learning were shared and discussed at handovers and staff meetings. We saw learning boards within the unit.

Trust level

From April 2018 to March 2019 the trust received four complaints in relation to critical care at the trust (0.4% of total complaints received by the trust). The service took an average of 60.8 days to investigate and close complaints, this was not in line with the trust’s complaints policy, which states complaints should be completed within 35 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>3</td>
<td>75.0%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From April 2018 to March 2019, the trust did not receive any compliments related to critical care.

The trust stated that compliments are received through the CEO office, these were responded and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust also stated that they received multiple compliments via their social media platforms and directed compliments to areas across the trust. The trust is currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. The unit could demonstrate where improvements had been made from previous incidents. For example, staff could describe a previous complaint which related to communication and the actions they had taken to prevent this reoccurring.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
The critical care service consisted of three areas which reported into the surgical division. Managed by a clinical intensivist lead and a matron. Nursing and medical staff within the critical care unit that we spoke with consistently described leaders as helpful and approachable. The senior leadership team were passionate about delivering high quality safe patient care and spoke with pride about a multidisciplinary team that provided a shared focus on high standards of care.

Leaders understood the challenges to quality and sustainability. Actions were taken to provide a safe and efficient unit. For example, during staffing difficulties the team had expressed their concern over increasing work pressures within the unit. The CCU management listened to their concerns which led to a reduced number of available bed spaces used until staffing levels were appropriate.

In line with national guidance the nursing team was led by a matron recognised as having overall responsibility for the nursing elements of the service and a designated Clinical Director for Intensive Care. Both the matron and clinical director had extensive experience within critical care. Staff spoke highly of both individuals, and said their judgements were respected.

The band seven nurses within the unit were allocated as clinical leads or clinical managers each weekday. Staff said this worked well as it ensured that all clinical and non-clinical requirements were met.

The trust had specific leadership training available to ensure nursing staff could carry out their role effectively. For example, there were band six and band seven leadership training courses run by the trust. Clinical leads within the unit explained that band six and band five nursing staff, were given the opportunity to shadow the clinical leadership for the day. This increased staffs’ knowledge base and understanding of the running of the unit.

The matron had an ‘open door’ policy for staff. The matron was knowledgeable about the unit’s performance against the trust priorities and the areas for improvement. There were examples of initiatives on the unit to improve patient care, such as new pathway developments and the introduction of a safety huddle. Staff were aware of their roles and took responsibility for adhering to expected standards.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

During our inspection staff were aware of the trust values and strategy. The trust vision, mission statement and values were all visible in the unit.

The values were called PIVOT, ‘patients first, continuous improvement, value all, open and honest and work as a team’.

Staff we spoke with were aware of PIVOT and what it meant for their jobs.

A new trust wide vision was launched in 2019; ‘proud to deliver high quality, compassionate care to our community’. This incorporated five strategic priorities. These were sustainability, people, pathways, ease of use and quality. The strategic priorities were designed and developed through a series of workshops that staff groups attended. Posters were displayed on the unit explaining how the strategy was important to their work.
The unit had developed their own critical care values, staff said they had all been involved in the development of the unit values.

- Challenge - poor practice, inappropriate behaviour.
- Respect - each other, values ideas and comments.
- Instil - team ethics, adherence to the code of conduct.
- Teamwork - handover set the tone for the shift, joint working.
- Inform - bedside teaching, keep teams up to date with changes in practice.
- Communicate - with family and each other.
- Act - respond to poor practice and behaviour
- Lead - by example, positive role model.
- Commitment – to the unit, your peers, to your individual teams. Attendance of team meetings and recruitment events.
- Acknowledge – understanding the needs of the trust and how it affects us.
- Remember – to act professionally. Code of conduct role modelling
- Everyone counts – think of staff as individuals, be inclusive.

The unit collected quality data to support operational and clinical decisions to evaluate clinical care and benchmark against other critical care units.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Throughout the inspection, staff told us they were happy with their work and their immediate team. There was a culture of collective responsibility between teams and services. Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns.

Staff we spoke with said they were treated equally and that there was no exclusion to different religions or sexual orientation. The trust had a workforce and race equality policy and had addressed any outstanding issues in an action plan, equality and diversity training was a mandatory training requirement.

The unit celebrated the achievements and hard work of staff. Staff were nominated by peers and relatives in a recognition award. This award was visible on the staff picture board in the main corridor to ensure that the identification was noticeable and valued.

Medical staff told us the nursing staff working was very patient centric, “never see them not interacting with patients” “very pleasant, hardworking”. We spoke with doctors who told us that they were well-supported and had a good working environment.

Staff were aware of the trust freedom to speak up policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that
concerns would be taken seriously. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the freedom to speak-up guardians.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. The unit was allocated within the surgical directorate. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

The CCU had monthly staff meetings which included discussions regarding incidents, complaints, activity in the service including cancellations, bed occupancy, finance, research, audits, workforce, sickness and education. These meetings fed into the two weekly band seven senior staff meetings. The CCU matron attended monthly divisional nursing meetings which discussed incidents, complaints, audits and other quality improvement initiatives.

The unit held meetings with the clinical lead, matron, senior staff and MDT team to discuss planned admissions for the week and to address any concerns they may have about the service. Daily consultant ward rounds were in place in accordance with the FICM core standards.

Mortality and morbidity reviews meetings were held weekly where timelines, management and learning relating to individual patients care were discussed. All staff within the unit were invited to attend, nursing staff said they found this very helpful as it increased their knowledge of different patient conditions. The outcomes and discussions from this meeting were cascaded during trust quality improvement meetings.

The clinical intensivist lead and unit matron attended quarterly East of England critical care meetings. These meetings provided a regional network in which to discuss ICNARC audit results and lessons learnt from incidents.

Medical staff we spoke with commented on the open discussions at the departmental and divisional meetings. They felt there was a strong governance structure and no blame culture which encouraged improvement and accountability.

Local Safety Standards for Invasive Procedures were in place for a number of standards including the safety checklists for bronchoscopy (looking onto the airways with a camera), central line (long cannula into neck veins) insertions and intubations (breathing tubes into the windpipe). Staff were aware of local safety standards within the unit.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk register in place that detailed the risks, actions to mitigate them, the level of risk, a risk owner and a review date. There were nine risks on the risk register. Risks included
ageing and/or insufficient equipment, staffing concerns, and delay in discharging level one patients. We saw that funding was being sought for more equipment and staff.

All risks were input on the electronic system by the governance team to ensure they had full oversight of them. Risks were owned by senior staff and the risks we reviewed were managed effectively. Risks were discussed and agreed at the divisional meetings before a risk was put on the register.

Risks were discussed at the morning safety huddles which included any staffing concerns and equipment issues. During our inspection, a water leak had occurred in the ceiling of one of the patient bays. Staff addressed the issues methodically and efficiently; risk assessments had been put in place to ensure patient and staff safety.

Plans were in place to cope with unexpected events. During our inspection the electronic observation system stopped working. During the inspection the electronic observation system stopped working and ward staff changed to using paper charts to note patients’ condition. Critical care outreach team CCOT staff said that even though the system had failed, ward staff escalated unwell patients appropriately to them.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff 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.

Leaders within the service had a good knowledge of performance and where further improvements were needed. Information was used to measure improvements. There were service performance measures in place, which were monitored at governance meetings.

The trust had an information governance policy which described how information was managed and controlled through the trust’s policies and protocols. The policy identified measures that ensured the security of information that was held about patients and staff. In addition, the policy identified measures to be implemented in the event of an information governance breach. There had been no breaches in information governance reported during the past 12 months within the trust. During our inspection we saw no computers that were in use left unattended, patient information was kept secure.

The trust had a data protection policy in place, which incorporated the Data Protection Act 1998; staff received training on information governance as part of their mandatory training.

Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place, which ensured data was submitted to external providers as required such as serious incidents and ICNARC performance.

**Engagement**
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients and relatives were given the opportunity to provide specific critical care feedback using the learning from excellence form. Patients and parents could also provide feedback using NHS Choices.

Volunteers within the hospital worked collaboratively with the staff on CCU to provide support and assistance to patients and relatives. The butterfly volunteer service was a trust wide implementation.

The unit worked collaboratively with other trusts in the area through the critical care network group. We saw evidence of this during our inspection. The matron explained that this would encourage improved learning systems and provide a proactive approach to building relationships with other organisations.

CCOT had close links with other outreach teams within the country. The CCOT matron was in the process of developing a hospital at night programme with the assistance of external reviewers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The senior staff took decisive action to make improvements in the running of the critical care unit. They had regular meetings where learning was discussed in a variety of forums. For example, staff meetings and quality and governance meetings. There was evidence of a helpful and blameless culture.

The unit had had a proactive research ethos which improved patient outcomes. These included the 65 Trial which evaluated the benefits of having a lower blood pressure and the use of intravenous fluids (FLOELA). Pending research developmental programmes included the use of ‘connect my care’ apps and studies to promote the use of specific drugs to improve patients’ nutritional needs.

The outreach team audited patient outcomes associated with a cardiac arrest. Learning outcomes established were discussed at patient safety meetings. The CCOT were in the process of developing a more integrated working process with the sepsis specialist nurses and acute kidney injury nurse specialists. Staff we spoke with said that they felt it was a beneficial innovation that it would improve patient safety within the trust.
Services for children and young people

Facts and data about this service

Acute services for children and young people at the trust are provided at the Lister Hospital site on the following wards:

Bluebell Ward - a 20 bed general inpatient ward for patients aged 0-16 years with both medical and surgical conditions and is a POSCU Level 1 service.

Children’s day services - this service provides care for patients aged 0-16 years requiring any day procedure including surgery and investigations. The service also provides nursing and support staff for all dedicated paediatric outpatient services provided at the Lister Hospital, QEII Hospital and Hertford Hospital sites.

Neonatal unit - a level 2 neonatal unit comprising of 30 cots and a transitional care unit. The cots are broken down into 20 special care cots, four ITU and six HDU with can be flexed.

(Source: Routine Provider Information Request (RPIR) – Context acute)

The trust had 9,374 spells from February 2018 to January 2019.

Emergency spells accounted for 82% (7,677 spells), 16% (1,510 spells) were day case spells, and the remaining 2% (187 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from February 2018 to January 2019, East and North Hertfordshire NHS Trust.

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>Lister Hospital</td>
<td>9,373</td>
</tr>
<tr>
<td>This trust</td>
<td>9,374</td>
</tr>
<tr>
<td>England total</td>
<td>1,147,968</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
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 made sure most staff completed it.

Mandatory training completion rates

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

Nursing staff received and kept up-to-date with most of their mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the children’s services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>150</td>
<td>154</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>150</td>
<td>154</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>149</td>
<td>154</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>149</td>
<td>154</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>138</td>
<td>145</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>144</td>
<td>154</td>
<td>93.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>133</td>
<td>154</td>
<td>86.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>120</td>
<td>154</td>
<td>77.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within children’s services, the 90% target was met for six of the eight mandatory training modules for which qualified nursing staff were eligible.

Medical staff kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in the children’s services department at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
</tbody>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL Page 138
Within children’s services, the 90% target was not met for any of the seven mandatory training modules for which medical staff were eligible.

**Lister Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the children’s services at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</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>138</td>
<td>142</td>
<td>97.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>138</td>
<td>142</td>
<td>97.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Year</td>
<td>137</td>
<td>142</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>137</td>
<td>142</td>
<td>96.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling for People Handlers - 2 Years</td>
<td>126</td>
<td>133</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>132</td>
<td>142</td>
<td>93.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>122</td>
<td>142</td>
<td>85.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>109</td>
<td>142</td>
<td>76.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within children’s services at Lister Hospital, the 90% target was met for six of the eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in the children’s services department at Lister Hospital is shown below:
Within children’s services at Lister Hospital, the 90% target was not met for any of the seven mandatory training modules for which medical staff were eligible.

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

The information provided above in the tables indicated that staff were not compliant with mandatory training targets. However, information provided during inspection showed that the data was inaccurate, due to issues with the reporting system. We saw evidence that all consultants were 100% compliant and that other grade medical staff were compliant with all mandatory training except fire safety, information governance and equality and diversity. We saw that training programmes were in place to get all staff to compliance. We also saw on inspection that nursing staff were 93% compliant with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. 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. 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. However, there was no specific mental health training.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities and autism. Some staff told us they did not receive any specific training in treating patients with learning disabilities or autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us they received automated reminders when staff needed to update their training. These reminders were received four months before the training was due to expire, and again at one month before.

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.

Safeguarding training completion rates
The trust set a target of 90% for completion of safeguarding training.

Most nursing staff received training specific for their role on how to recognise and report abuse.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the children’s services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>152</td>
<td>154</td>
<td>98.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>151</td>
<td>153</td>
<td>98.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>146</td>
<td>154</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>145</td>
<td>153</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>131</td>
<td>147</td>
<td>89.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within children’s services, the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the children’s services at trust level is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>34</td>
<td>41</td>
<td>82.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>35</td>
<td>44</td>
<td>79.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>28</td>
<td>41</td>
<td>68.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>29</td>
<td>44</td>
<td>65.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Within children’s services, the 90% target was not met for any of the five safeguarding training modules for which medical staff were eligible.

**Lister Hospital**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the children’s services at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>34</td>
<td>41</td>
<td>82.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>35</td>
<td>44</td>
<td>79.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>28</td>
<td>41</td>
<td>68.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>29</td>
<td>44</td>
<td>65.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
qualified nursing staff in the children’s services at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>140</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>139</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>134</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>133</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>120</td>
</tr>
</tbody>
</table>

At Lister Hospital children’s services, the 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible. The target was close to being met for the other training module with a completion rate of 88.2%.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the children’s services at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 1 Year</td>
<td>12</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>34</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>35</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>28</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>29</td>
</tr>
</tbody>
</table>

At Lister Hospital children’s services, the 90% target was not met any of the five safeguarding training modules for which medical staff were eligible.

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

The information provided above in the tables indicated that staff were not compliant with safeguarding training targets. However, information provided after the inspection showed that the data was inaccurate, due to issues with the reporting system. We saw that safeguarding level 3 training compliance was at 100%. The safeguarding team also provided a wide variety of safeguarding training events including debriefs and case reviews where safeguarding training was given. These were not shown in the safeguarding training data.

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 healthcare staff (2018)’ 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.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff explained the different protected characteristics under the Equality Act and were aware of the importance of being inclusive to all patients. Staff wore a rainbow NHS badge to show inclusivity for patients who were lesbian, gay, bisexual, transsexual, queer, intersex or asexual (LGBTQIA+).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. 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. The safeguarding team had strong links with the local police and social services and conducted regular meetings with them. If a safeguarding concern was raised, staff would liaise with other professionals including GP’s, health visitors, school nurses, and social workers. A specialist safeguarding hub was located within Bramble ward, which included two ‘achieving best evidence’ suites. These were used by the police when conducting interviews with people who were alleged victims of abuse. A medical examination suite was also in Bramble ward, where staff conducted medical examinations on children alleging physical abuse or neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe the actions they would take to raise a safeguarding concern and were well supported by the safeguarding team. Posters detailing the contact numbers of the local safeguarding board were displayed on the wards and staff were familiar with them. The safeguarding team were based on Bramble ward but regularly visited the other wards to give advice to staff.

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, county lines drug trafficking and other local issues.

A child protection icon had been added to all children’s electronic records. Therefore, if they attended for emergency care, it would be identifiable that a child protection plan was in place. We saw these working during our records review.

The trust had policies on CSE and female genital mutilation (FGM). Information about CSE and FGM was disseminated to staff by safeguarding champions. These were nurses who had a particular interest in safeguarding and had close links with the safeguarding team. A CSE toolkit had been developed. This was a two-part toolkit, with part 1 being a reminder of five key questions to ask, and part 2 being a proforma for clinicians to complete if they had concerns.

We observed two handovers and saw that safeguarding concerns were raised to ensure all staff were aware. These included any child and adolescent mental health services (CAHMS) patients on Bluebell ward and any concerns regarding court ordered protection plans on the neonatal ward.

Every two weeks multidisciplinary (MDT) psychosocial meetings were held where any safeguarding issues were discussed. These included new concerns, ongoing referrals and
learning from previous cases. We saw that all relevant medical tests and examinations were conducted to aid the safeguarding team in deciding whether further action was necessary to protect the child.

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. The trust had a 90% target for staff to complete safeguarding supervision. We saw that safeguarding supervision was offered to staff every three months for band 6 and 7 staff working in paediatric and neonatal units. Uptake of safeguarding supervision was low, with 68% of staff compliant with the supervision standard. The safeguarding team were aware of this and were talking with staff members for their reasons for non-attendance.

The safeguarding team also received external supervision from the local clinical commissioning group (CCG). Plans were in place to increase the accessibility of the external CCG supervision to more staff in the future.

We reviewed the department’s safeguarding children annual report 2017-2018. During this reporting period 414 referrals were made to children’s social care due to concerns for an unborn baby, child or young person’s welfare. In the same time period 236 child protection medical examinations were undertaken by paediatricians, mainly for concerns regarding physical abuse.

A list had been created by the safeguarding team which included various indicators that a child or young person could be being abused. These included injuries with an unknown origin, dog bites, non-school attenders and needle stick injuries. This had been shared with the staff on the wards and since its introduction the safeguarding team had seen a 39% increase in the number of referrals they had received from the wards.

The trust had a chaperone policy 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. In most cases this was the child’s parent or guardian, however, in cases where there were allegations of parental abuse, a member of the safeguarding team was used.

We reviewed the department’s safeguarding children annual report 2017-2018. During this reporting period 414 referrals were made to children’s social care due to concerns for an unborn baby, child or young person’s welfare. These were then discussed in case reviews to ensure learning was shared with the teams. In the same time period 236 child protection medical examinations were undertaken by paediatricians, mainly for concerns regarding physical abuse. Prior to our inspection the department had recently stopped doing undertaking examinations where suspected sexual abuse had taken place.

Staff followed safe procedures for children visiting the ward. Entry to Bluebell ward and the NNU was by swipe access or video-controlled intercom, where visitors had to be cleared for entry by staff.

**Cleanliness, infection control and hygiene**
The service’s control of infection risk was variable. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas of the ward were visibly clean. Furniture was in good condition with no rips and the flooring was wipe clean and compliant with Department of Health requirements, regarding smooth edges and no coving, to reduce the risk of dust or bacteria accumulating. A specialist play room had been created solely for children with cancer. This was to allow them to have an area to play during their chemotherapy treatment, to minimise the risk that any viruses or infections from the other children would be passed on. This play room was cleaned by the play specialists in between each child.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.64 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)

Hand sanitiser was available at the entrances of all clinical areas and in the wards and single rooms. During our previous inspection we raised concerns about the location of hand sanitisers on the neonatal unit (NNU). We saw that following this the ward had moved the location of the hand sanitisers so that they were easily accessible.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We looked at cleaning records across the wards and saw that bedside and cot side areas were cleaned regularly. 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.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we saw were compliant with infection control measures. These included long hair being tied back, arms being bare below the elbow and using PPE such as gloves and gowns. All parents and patients we spoke with confirmed they had seen staff washing their gowns before conducting any examinations or treatment. Regular infection control audits were completed by the infection control team. We reviewed three and saw that compliance ranged from 90% to 100%.

Side rooms were available on both NNU and Bluebell ward to admit children or babies with a known or suspected infection. We saw signs were displayed on these to make it clear to staff and visitors. Babies who were too young to have had any of their immunisations were also housed in the side rooms if available.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All the equipment we saw was clean and had ‘I am clean’ stickers placed so we could see when they were last cleaned. COSHH (Control of substances hazardous to health) cleaning chemicals were stored securely.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. All beds had call bells within reach of patients, with the exception of CAHMS patients on
Bluebell ward. These had been removed for safety reasons as they could be used to self-harm. However, the CAHMS patients had 1:1 observation from a staff member and therefore, did not need a call bell.

The design of the environment did not always follow national guidance. At our last inspection we raised concerns about the safety of an equipment room which housed a fire door on Bluebell ward which children could open and gain access to outside bins (including sharps bins) and go through to the car park and main road. As a result of us raising concerns staff had changed the handle of the equipment room to a high handle which meant small children would not be able to open it. However, we were still concerned that older children and teenagers could open the door into the equipment room and leave the building through the fire door. As the fire door was not alarmed staff would not be made aware of this happening. We were particularly concerned about this as CAHMS patients sometimes attended the ward. Although we were assured that CAHMS patients showing suicidal tendencies would have 1:1 observation, we were told that not all CAHMS patients did and therefore, we were concerned about teenagers at risk of self-harm, having access to sharps bins and the main road. We raised this as a concern, following which the estates team conducted a fire door risk assessment which resulted in alarms being fitted at the end of July 2019.

We also found in another unlocked equipment room a bucket containing used batteries. This was on a mid-level shelf, which would be accessible to older children and teenagers but not young children. The door to the equipment room was adjacent to patient bays, including one which had a CAHMS patient with a history of ingesting batteries as a method of self-harm. We immediately raised this as a concern and removed the bucket of batteries. We saw staff moved this to a locked room immediately.

Access to the NNU and Bluebell ward were accessed via secured door with intercom. Visitors pressed a buzzer and waited for staff to confirm their identity. Signs were in place to warn visitors about allowing other people to enter the ward with them. The door to Bramble ward was unlocked, though the previous door leading to the hallway required buzzer entry. We were told plans were in place to get funding for a buzzer intercom lock for Bramble ward. However, as this was not used as an overnight ward, and used predominantly for ambulatory care such as allergy testing, there was a smaller chance of children being left unattended by their parents or guardians.

The toilets and bathroom facilities were clean and generally well maintained. There was a disabled toilet available in the corridor outside Bluebell ward. 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. We raised this as a concern at our last inspection and saw that none had been installed. There was one emergency buzzer outside the cubicles.

Staff we spoke with were aware that as the wards were not specialist CAHMS wards, there were ligature points. We were told that the risk of ligature was reduced for CAHMS patients as those identified as being at risk of suicide were accompanied by 1:1 observation at all times. We saw this in place for a CAHMS patient during our inspection. We requested a copy of the most up to date ligature risk assessment and saw that there were two ligature concerns listed. These were in relation to blind cords and call bells within the toilets. Both had mitigating actions.

During our last inspection we raised concerns regarding sewage coming up through the shower units in the parents’ rooms on the NNU. This was on their risk register last time. During this inspection we saw that this was still an issue, however, it was no longer on the risk register. We were told it was due to parents flushing inappropriate items down the toilet, leading to a blockage
in the pipes. Signs were displayed warning parents against flashing inappropriate materials, but we were told this still occurred occasionally.

During our last inspection we raised concerns about the security of the milk kitchens on the NNU. Last time we found that the milk kitchens were not secure and therefore, we could not be assured that the milk stored in the fridges and freezers had not been tampered with. During this inspection we saw that although the door to the milk kitchen was not always locked, unauthorised access was prevented as the corridor leading to the milk kitchen was swipe access only. Expressed breast milk was labelled clearly and each baby had their own shelf in the fridges and freezers to avoid accidental contamination. The temperatures of the fridges and freezers were recorded daily on checklists.

There was exclusive use of the day surgery unit for children two days per week for elective surgery. 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 children were in recovery. Children were recovered from their anaesthetic near to the nurses’ station. Staff told us they supplied toys for children.

On other days when children had emergency surgery, adults recovered from an anaesthetic in the same recovery area, separated by a screen. 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”. The department had a risk assessment in place to cover situations when adults and children were recovered alongside each other.

A well equipped outside play area and inside play room was located on Bluebell ward. There were separate play rooms for teenagers with age appropriate games consoles; oncology patients to reduce the risk of infection, and a sensory room with music and sensory lights for babies or children with autism who may suffer from processing and over stimulation difficulties.

Staff carried out daily safety checks of specialist equipment. We reviewed three resuscitation trolleys and found that these were checked daily. We also saw that specialist equipment in the NNU including ventilators were checked daily.

The service had suitable facilities to meet the needs of children and young peoples’ families. On Bluebell ward, each bay and side room had a camp bed for parents or guardians to stay with their child. On NNU there were four parents’ rooms where parents could stay on the ward. These were used predominantly for babies who were about to be discharged home, so that it could be an easier transition for the parents. A parents’ lounge was also available within the NNU, and plans were in place to expand this to create more space for them.

There were two expressing rooms, equipped with breast pumps, for mothers to pump breast milk for their babies in the NNU.

Prior to our inspection two interactive floors were installed, one in the ED and one in Bramble ward. These allowed children to play on the floors and encouraged them to move around.

The service had enough suitable equipment to help them to safely care for children and young people. At the time of our inspection there was sufficient quantities of equipment. However, we were told that there was no plan in place to address the ageing equipment used in the NNU. This was a concern we had raised at the last inspection and was still a concern in July 2019. This was on the NNU’s risk register and capital bids were being placed to request funding for more equipment. We were told that two incubators from the special care baby unit (SCBU) had been
condemned and that the SCBU had to borrow two incubators from the high dependency unit (HCU) to meet demand. We were also told that the majority of their equipment including ventilators and cardiac monitors were very old and would soon be unusable, but no plan was in place for managing this.

All equipment we reviewed had received in date electrical safety testing and regular servicing. We reviewed three resuscitation trolleys and found all equipment to be in date. Tamper tags were in place to ensure the security of the equipment inside the trolleys.

Staff disposed of clinical waste safely. 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.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, this was not always the case in day surgery where children who were deteriorating would not always be readily identified from the PEWS score. Staff used the paediatric warning score (PEWS) to identify deteriorations in a child’s vital signs and used appropriate escalation measures. The department used an electronic PEWS system using smart phones. Staff inputted a child’s observations, including heart rate, respiratory rate, temperature, blood pressure, pain score and oxygen saturations. The system then calculated their PEWS score. If the child ‘triggered’ it would prompt staff to escalate to the medical team. During our inspection the electronic system was temporarily not working and we saw staff reverted to paper based PEWS charts instead.

PEWS charts were not included in the observation booklets used in the day case surgery unit. This was because the surgery unit still used paper charts and there were four versions of PEWS charts, depending on the child’s age. We were told that they had decided not to include these in the booklets as it would make them too long and there would be too much unnecessary paper. Instead, PEWS calculation charts were laminated and displayed on the walls and we were told staff would look at these and calculate the child’s PEWS score and see if escalation was required. However, there was no section in the paper booklet for PEWS scores to be calculated, and therefore, there was no evidence that this had been done. Furthermore, as there was nowhere to record the PEWS score, it was not clear how staff would identify a deteriorating child as there would not be a list of worsening PEWS scores. We raised this as a concern and were told that plans were in place to redesign the booklets to include a section for staff to calculate the PEWS score.

On the NNU staff used the neonatal alert track and trigger to identify deteriorating babies. We saw evidence that 92% of staff were trained in using the tool.

Staff completed risk assessments for each child and young person on admission / arrival and updated them when necessary and used recognised tools. All patients had a set of vital signs completed on admission, which was entered onto a PEWS chart. Depending on the child’s PEWS score these were reviewed by medical staff and observations were repeated at set intervals.

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. VIP scores are used to monitor the sites of intravenous (IV) lines to check for signs of infusion phlebitis (inflammation of the vein the IV goes into).

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.

There were two resuscitation bays in the paediatric emergency department.

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. Data provided by the trust prior to our inspection showed that the service was not achieving 100% completion of the World Health Organisation (WHO) Five Steps to Safer Surgery checklists. The notes we reviewed in the day unit had the WHO checklists completed appropriately. We reviewed the last three WHO audits. This showed that in March 2019 one patient did not have time out completed, in April 2019 one patient did not have time out and one did not have sign out completed, and in May 2019 there were no omissions.

Staff knew about and dealt with any specific risk issues. 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 conducted quarterly (four times per year). These were trust wide audits and as such, included few paediatric patients. The service exceeded the 90% screening target for three out of four quarters in 2018-2019. The other quarter the service met the screening target for 86% of patients. The service was consistently not meeting the expected target of 90% treatment time (patient with sepsis being started on antibiotics within one hour). The department’s rate for treatment was 33%. Actions taken to improve this included increased staff teaching and monthly audits. We saw that there had been no serious incidents relating to sepsis in children’s ED.

Quarterly febrile neutropenic audits were completed in line with their POSCU (Paediatric Oncology Shared Care Unit) status. National Institute for Health and Care Excellence (NICE) guidance CG151 states that all febrile neutropenic patients should receive antibiotics within 60 minutes of arrival at hospital. The department’s audits showed that from October 2018 to January 2019 eight patients had antibiotics within 60 minutes, two patients within 90 minutes and one patient within 120 minutes. They found the main cause of delay was delays in getting the blood samples to the laboratory. Therefore, a new process was in place for staff to deliver blood samples by hand instead of waiting for a porter.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person’s mental health). Child and adolescent mental health services (CAMHS) were provided by another NHS trust. They provided a children’s crisis
assessment and treatment team (C-CATT) which operated between 9am and 9pm, Monday to Friday, and Saturday and Sunday mornings. If a child or young person presented with mental health concerns outside of these times, staff referred to the adult rapid, assessment, interface and discharge (RAID) team for advice. The service was unable to extract data to show how often CAMHS patients were admitted to general paediatric ward due to a lack of suitable mental health beds. They estimated this happened once a month and said this usually occurred while waiting for a tier 4 bed. (Specialised services that provide assessment and treatment for children and young people with emotional, behavioral or mental health difficulties.)

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. We saw that these were completed by the CAHMS team in conjunction with the safeguarding team where necessary.

Staff shared key information to keep children, young people and their families safe when handling over their care to others. Shift changes and handovers included all necessary key information to keep children and young people safe. We observed two handovers, one on Bluebell ward and one on the NNU and saw that information relating to risks were shared. Topics included recent blood results, feeding methods and oxygen therapy.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.31 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 9.17 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.

**CQC Children and Young People’s Survey 2016 questions, safe domain, East and North Hertfordshire NHS Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.64</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.31</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<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>9.17</td>
<td>Worse than other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Neonatal simulation scenarios were undertaken twice per month for the management of neonatal resuscitation. A dedicated neonatal simulation room was located within the NNU. The scenarios incorporated members of the multidisciplinary team, including paediatricians, anaesthetists, healthcare assistants and nurses. Five staff members on the NNU were neonatal simulation trainers. At the time of our inspection, the simulation dummy was that of a full-term baby, but we
were told that funding was being sought to purchase a smaller dummy to emulate a premature baby. Abduction drills were not performed on the NNU or Bluebell ward.

At the time of our inspection there was a backlog of approximately 157 discharge summaries and zero children lost to follow up for outpatient waiting list appointments. This meant that there was a potential risk of patients not accessing follow up treatment or investigations in a timely manner. We were told the delayed discharge summaries were mainly from the surgical division. For more information on the backlog in the surgical division please refer to the surgical report. Senior staff told us that the data provided on the number of delayed discharge summaries was not accurate due to user error with the electronic system. We were told that some of the letters had been sent but that it did not show up on the system, and that others had been held back due to staff not ticking the correct boxes on the system and ward clerk sickness. To improve the position on discharge summaries, each day a doctor on the children’s assessment unit was ringfenced from 12pm to 2pm to work solely on discharge summaries. It was projected that the service would be up to date on discharge summaries by the end of August 2019.

Transition services were in place for young people who were transitioning from children’s to adult services. A children’s and young person’s transitional group was led by an adult consultant and had multidisciplinary input. Specialities involved in this group included paediatric diabetes and epilepsy. For more information on transition services please refer to the responsive section of this report.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep children and young people safe. A dedicated paediatric nurse was available in the day surgery unit, Monday to Friday, from 8am to 2.30pm to help with any emergency admissions and discharges. The department also employed three registered nurse associates. Emergency nurse practitioners were employed in the CAU and provided cover from 10am to 10pm, seven days a week.

Nurse staffing rates within services for children and young people at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

20191218 RWH Post-inspection Evidence appendix FINAL
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives in services for children and young people at trust level were not stable and may be subject to ongoing change.

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

Agency staff usage

Monthly agency hours over the last 12 months for registered nurses, health visitors and midwives in services for children and young people at trust level were not stable and may be subject to ongoing change.

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

Lister Hospital

The service had low vacancy rates. The service had low turnover rates. The service had higher sickness rates than target.

The table below shows a summary of the nursing staffing metrics in services for children and young people at Lister Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>April 2018 – March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>Target</td>
<td>6%</td>
</tr>
<tr>
<td>All staff</td>
<td>3%</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)
Nurse staffing rates within services for children and young people at Lister Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

Monthly vacancy rates over the last 12 months for registered nurses, health visitors and midwives were not stable and may be subject to ongoing change.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

The service had low and reducing rates of agency staff.

**Agency staff usage**

![Agency hours - qualified nurses, health visitors and midwives](chart)

Monthly agency hours over the last 12 months for registered nurses, health visitors and midwives in services for children and young people at Lister Hospital were not stable and may be subject to ongoing change.

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

We saw that agency staff were rarely used within the department and had not been used since January 2019. Instead, substantive staff took on extra shifts as bank workers, which meant that they were familiar with the wards and patients.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The
paediatrics department managed staffing across the children’s emergency department, children’s assessment unit (CAU), bluebell ward and children’s day services, which included day surgery, outpatients and ambulatory care. The team reviewed each area daily and redeployed staff throughout the department where required to fill gaps in rotas.

Staffing levels on Bluebell ward were planned via an electronic system ‘Safe Care’ which compared staffing levels and skill mix against patient numbers and acuity (medical complexity). Safe Care 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.

The NNU staffing levels were planned in accordance with the British Association of Perinatal Medicine (BAPM) standards, however, they did not meet this for all shifts. Planned levels included:

- 1:1 (one nurse per child) staffing for intensive care for babies with serious life-threatening problems, born more than three months early or weighing less than 1000g.
- 1:2 (one nurse per two children) staffing for high dependency care for babies recovering from critical illness or require substantial observation.
- 1:4 (one nurse per four children) staffing for special care for babies who are stable and growing, with less serious problems.
- 1:4 (one nurse per four children) staffing for transitional care for babies who require medical treatment but can stay with their mother.

Data we were provided with on site showed us that the NNU met BAPM standards 80% of the time. From April 2018 to March 2019 131 shifts were not compliant with BAPM standards. In order to reduce the risks of not meeting BAPM standards for all shifts, the matron always scheduled qualified in specialty (QIS) nurses to work in the HDU and ITU.

The NICU used the ‘badger net’ to input and monitor staffing levels. This allowed them to benchmark against 17 other NICUs in the East of England via their operational delivery network.

The ward manager could adjust staffing levels daily according to the needs of patients. Whilst we were on inspection we saw managers moving staff across the wards to cover staff shortages and respond to increased patient numbers. Regular meetings were held which discussed staffing requirements and allowed managers to flex staff where needed. Safe Care RAG rated (rated as red, amber or green) ward staffing levels depending on patient acuity. This then meant it was clear which wards could flex staff to other wards.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. During our inspection we saw the wards were fully staffed. We reviewed the last three months planned and actual staffing levels and saw that staffing levels were sufficient. We saw shifts were RAG (red, amber or green) rated and that staff were moved between wards depending on staffing levels and patient acuity.

Nursing handovers happened at the change of each shift. We observed two handovers and saw that they were well structured and concise. Handover meetings on Bluebell and paediatric ED took place in office and meeting room areas to ensure that patient confidentiality was maintained.

The nursing handover on the neonatal unit occurred in a seminar room which ensured privacy. Staff were allocated to patients, dependent upon their qualifications. For example, babies requiring HDU or ITU care were allocated to QIS nurses. The matron also attended a huddle in the maternity unit to gain an overview of potential admissions to the neonatal unit.
Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. 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 9pm, seven days a week. Between 9pm - 8:30am there was on-call consultant cover. There were 12 acute paediatric consultants. During our last inspection there were nine. There had been a recruitment drive to employ more overseas doctors which had led to a lessening reliance on locum doctors. There were five neonatal consultants. 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.

The medical staff matched the planned number on most shifts in each department.

The service had a higher than target vacancy rate for medical staff. The service had low turnover rates for medical staff. The service had low sickness rates for medical staff. The service did not provide a target for locum hours, but per the below chart, the service used 1,724 hours of locum staff from April 2018 to March 2019.

The table below shows a summary of the medical staffing metrics in services for children and young people at trust level compared to the trust's targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>281</td>
<td>5%</td>
<td>6%</td>
<td>4.8%</td>
<td>5,535</td>
<td>1,724</td>
<td>691</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td>55</td>
<td>14%</td>
<td>2%</td>
<td>2.6%</td>
<td>5,535</td>
<td>1,724</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within services for children and young people at the trust were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use.
Monthly vacancy rates over the last 12 months for medical staff in services for children and young people at trust level were not stable and may be subject to ongoing change.

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

Monthly sickness rates over the last 12 months for medical staff in services for children and young people at trust level showed an upward trend from June 2018 to December 2018.

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

Locum staff usage
Monthly agency hours over the last 12 months for medical staff in services for children and young people at trust level showed a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Lister Hospital

The table below shows a summary of the medical staffing metrics in services for children and young people at Lister Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>245</td>
<td>3%</td>
<td>5%</td>
<td>4.8%</td>
<td>5,535</td>
<td>1,724</td>
<td>691</td>
</tr>
<tr>
<td>Medical staff</td>
<td>55</td>
<td>14%</td>
<td>2%</td>
<td>2.6%</td>
<td>5,535</td>
<td>1,724</td>
<td>691</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within services for children and young people at Lister Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

Vacancy rates

Monthly vacancy rates over the last 12 months for medical staff in services for children and young people at Lister Hospital were not stable and may be subject to ongoing change.
Sickness rates

Monthly sickness rates over the last 12 months for medical staff in services for children and young people at Lister Hospital showed an upward trend from June 2018 to December 2018.

Locum staff usage

Monthly locum hours over the last 12 months for medical staff in services for children and young people at Lister Hospital showed a shift from October 2018 to March 2019.

Managers made sure locums had a full induction to the service before they started work. Staff confirmed that locums had thorough inductions prior to starting work. This ensured that they were familiar with the service, the layout of the wards and the patient acuity.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.
Staffing skill mix

In February 2019, 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.

Staffing skill mix for the 49 whole time equivalent staff working in services for children and young people at East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Staffing Skill</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>53%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>36%</td>
<td>44%</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 always had a consultant on call during evenings and weekends. During evenings and weekends consultants on call remained within 30 minutes of the hospital site, so that they could come in quickly and easily if needed. Staff we spoke with said that consultants came in when required.

Ward rounds occurred on weekend mornings. Following this, consultants went home, but remained on call.

An additional registrar was introduced during the winter months to help assist with winter pressures. They were based on CAU and the NNU. Previously, there was one registrar who covered Bluebell ward, the NNU, the emergency department and CAU. Staff told us the introduction of a second registrar to assist at night was very helpful.

Consultant anaesthetists were available 24 hours a day if a child required emergency surgery.

Medical handovers occurred three times a day. We observed two handovers, one on Bluebell ward and one on the NNU. Both were well structured and shared appropriate information.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 14 sets of records and saw that these were legible, complete and showed evidence of MDT input.
When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff we spoke with told us this was a smooth process, however, some parents told us that they felt they had to repeat themselves whenever a new team took over their child’s care.

Records were stored securely. Records were stored securely, both electronically and in paper format. Paper records were stored in locked record cupboards. Electronic records required staff to sign in to gain access. We saw staff locked computers when they stepped away from them. Electronic records included observations of vital signs, PEWS scores and information about children, such as if they were subject to a child protection plan.

During handover staff took notes on paper. Staff told us that they were securely destroyed at the end of each shift, to ensure patient confidentiality. However, we found discarded documents with babies’ names, address and NHS numbers on the NNU unit within reach of visitors on the unit. We saw a box by the nurses’ station which contained a number of documents. The box was labelled for shredding, but it had an open top. We were told this was used to store confidential paper waste before being taken to the main secure shredding bin. We raised concerns about the confidentiality of the documents and it was moved behind the nurses’ desk.

We saw personal child health records, ‘red books’ in the NNU to be given to parents upon their baby’s discharge. These were also updated when children attended the emergency department and measurable metrics such as height and weight were recorded in them.

**Medicines**

**The service did not always use systems and processes to safely prescribe, administer, record and store medicines.**

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. We found that arrangements for the storage of controlled drugs (CDs) did not meet best practice. CDs were stored within a locked cupboard, inside a locked room. Keys were stored in a keypad safe which required a keycode.

On Bluebell ward we checked the CD register and saw that these were administered by nursing staff and witnessed appropriately by another professional member of staff. This was compliant with the Nursing and Midwifery Council Standards for Medicine Management (2007). However, inside the CD cupboard we saw stock CDs (hospital’s own) on the same shelves as patients’ own CDs they had brought in from home. As such, there was a risk that patients’ own CDs could be administered instead of stock CDs. We also found that the recording of administering patients’ own CDs did not meet best practice. More than one patient’s CDs were recorded on pages of the patients’ own CD book, when only one patient per page should be recorded. We also found that more than one CD per patient was recorded on the same page. Furthermore, we saw that it was not always clear when patients’ own CDs were administered, some dates were missing, and entries made retrospectively were not marked as retrospective. Following us raising this as a concern senior leadership sent a memo to all staff reminding them of best practice.

On Bluebell ward we also found that antibiotics prescribed for children did not always have an end date or length of duration. As such, it was unclear how many doses children should have had and there was a risk they would have more or less antibiotics than needed. Nursing staff had not clarified the instructions with the prescriber and were administering these medicines to children. We also found that when the dose of some antibiotics was changed this had not been appropriately recorded as per the Trust’s policy and national guidance.
On Bluebell ward we found one instance where a child was being given intravenous (IV) fluids without evidence of prescription.

On our last inspection we found that oxygen was being administered to babies on the NNU and Bluebell ward without being prescribed or being on a patient group directive (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. We raised this as a concern at the last inspection and found that practice had improved at this inspection. The prescription charts had been amended to include a box which detailed the various oxygen saturation rates babies could require and medical staff ticked which target rate the baby needed.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A designated paediatric pharmacist visited the neonatal and paediatric wards Monday to Friday to review prescriptions and advise medical staff when doses needed to be revised. The pharmacist reviewed medicines and information provided to discharged patients. In the CQC Children and Young People’s Survey 2016 the trust scored 9.17 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.

We reviewed six sets of prescription charts and found that antibiotics were not always reviewed within 48 hours (on two records) and end dates for medications were not always listed (on four records).

Staff did not always store and manage all medicines and prescribing documents in line with the provider’s policy. We reviewed the medicine fridge temperatures in Bluebell ward and NNU and found that on Bluebell ward the temperatures were exceeding limits regularly. In June 2019 the fridge temperature was out of range on 16 occasions and in July 2019 up to our inspection they had been out of range on seven occasions. This was recorded in the fridge temperature log, but nothing had been done to mitigate this. The only action taken was to inform the nurse in charge. However, we saw no evidence that actions were put in place to prevent this happening again or that the shelf life of the medicines inside was shortened as they had been exposed to high temperatures. This was in conflict with the provider’s medicine management policy which stated that the pharmacy team should be informed immediately.

Staff followed current national practice to check patients had the correct medicines. When administering medications staff checked the identity of the patient and the medicine, the dose and the method of administration. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Information about recent safety alerts and incidents involving medications were shared at team meetings and handovers. We saw evidence of this in the team meeting minutes we saw. The department had a serious incident (SI) involving a medication overdose prior to our inspection. Staff were aware of this and the learning following it. More details on the SI can be found in the incidents section of this report.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. In the records we reviewed we saw no patients who were having their behaviour controlled by medicines.
Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All staff we spoke with knew how to report incidents and the types of issues that they should report. These included patient safety issues such as non-timely treatment and short staffing levels. Staff were familiar with the electronic incident reporting system.

Staff reported most of the incidents that they should report. Staff reported serious incidents clearly and in line with trust policy. The ward manager of the NNU told us that staff did not always report equipment failure as an incident. They said this was due to the fact they reported these frequently and rarely saw action being taken as a result, due to issues with funding. Therefore, they said they were aware of a culture of under-reporting equipment failure on the NNU. We were assured that the ward manager encouraged staff to continue reporting this and that staff did not under report other types of incidents.

Never Events

The service had no never events on any wards. 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 June 2018 to May 2019, the trust reported no incidents that were classified as a never event in services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in which met the reporting criteria set by NHS England from June 2018 to May 2019. The incident was classified as a medication incident meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

Managers debriefed and supported staff after any serious incident. We reviewed the one SI the service had in the reporting criteria. This involved a medication error, whereby a child was given an overdose of Dalteparin; a blood thinner. The child required active treatment following this due to increased postoperative bleeding. We saw that staff were debriefed and supported throughout the process.

We were unsure whether managers investigated incidents thoroughly. We requested the last three root cause analysis (RCA) incident reports but were only provided the rapid incident reports, which
lacked detail. Two of the incidents relayed to delays in treating oncology (cancer patients) and the third related to delays in x-rays being reported and MRIs being scheduled.

Patients and their families were involved in these investigations. Staff told us that duty of candour was applied when incidents occurred. Staff we spoke to knew what duty of candour meant. 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 received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with told us they usually received feedback following incidents, but that sometimes they had to seek it out. Team meeting minutes showed learning from incidents was discussed.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were reviewed at a variety of clinical governance meetings, where feedback and improvements were discussed.

There was evidence that changes had been made as a result of feedback. We saw in the NNU that there were concerns about babies’ temperatures dropping during the transfer process between maternity and NNU. We saw that as a result of this NNU staff were taking thermometers with them to the delivery room to get accurate temperatures throughout the transfer and identify where the heat loss was occurring. Staff provided examples of changes to practice as a result of incidents. An example of this included that Gentamicin (antibiotic) levels used to be tested by both medical and nursing staff in NNU. This led to an incident where one baby’s levels were not tested, as both groups of staff thought the other had performed the test. As a result of this, only nursing staff tested gentamicin levels.

Managers did not always share learning with their staff about never events that happened elsewhere. Not all staff we spoke with were aware of never events that had happened in other parts of the hospital.

**Safety thermometer**

**The service did not use safety thermometer results to improve safety. Staff collected safety information but did not always share it with staff, patients and visitors.**

Safety thermometer data was not displayed on wards for staff and patients to see. There were no posters visible during the inspection which told staff, parents or visitors about the level of harm free care.

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 took place on one day each month – a suggested date for data collection was given but wards were able to change this. Data was expected to 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 urinary tract infections, in patients with a catheter, from May 2018 to May 2019 for children’s services.

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. 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. The diabetes service was peer reviewed in 2018 by the Royal College of Paediatrics and Child Health. The peer review led to the service being rated excellent.

The service took part in a variety of national audits including the national paediatric diabetes audit (NPDA) and the national neonatal audit programme (NNAP). Details of their outcomes are noted below in the patient outcomes section of this report. Action plans were formed following these audits, with quality improvement plans developed. Local audits were also completed, on topics such as hand hygiene and paediatric early warning scores (PEWS). These showed generally positive results.

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 seven pathways, including management of anaphylaxis, management of enteral feeds and the prolonged jaundice pathway and found these were in date and compliant with national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff worked in conjunction with CAHMS staff to care for and treat patients subject to the Mental Health Act. The department also had a link nurse for mental health, who provided advice and support to other front line staff. 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 dealt with violence and aggression, if it arose. A sensory room was available within the play room area, for children who suffered from sensory overload and required a quiet calm place. ED staff had developed a tool for treating children and young people with mental ill health, in the absence of any national standardised evidence-based tool for the identification and monitoring of mental health patients. As a result of this, the team were asked to present this at an international conference. Weekly meetings were held with the local NHS mental health trust. Together they worked to try to avoid acute admissions and to make personalised care plans.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed this during the neonatal unit (NNU) handover where staff discussed worries and anxieties that a new mother felt about holding and feeding her premature baby. Staff discussed ways that they could help the mother and had a family liaison nurse whose role was to help in these types of scenarios.

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.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw that children on Bluebell ward were offered food and drink. One parent we spoke with told us that her child was woken in the early morning just before she was going to have to fast (withhold food), so that she had the opportunity to have something to eat and drink before she became nil by mouth prior to surgery. However, parents and carers were not routinely given food or drink. One parent we spoke with, whose child was a regular attendee on the ward, told us during the inspection they had been offered food that day, but that they had never been offered anything before.

Babies on the NNU were fed by either breastfeeding, expressed breast milk, infant formula or a mixture of the above methods. We saw a variety of infant formula milk was available, including specially hydrolysed milk for babies suffering with cow’s milk protein allergy. Babies on the NNU were fed by either nasogastric (NG) tube, cup feeding, syringe feeding or bottle feeding if not directly breastfed. There were two expressing rooms on the NNU for mothers to express breast milk. The infant feeding team offered their services five days a week, however, all staff had competencies in infant feeding. Parents were taught how to feed their babies upon discharge if their babies still relied on NG feeding.

Parents on the NNU were not offered food, despite some of the mothers breastfeeding and expressing breast milk for their babies. A water cooler was available for parents on the ward.

We saw children on Bluebell ward were given intravenous (IV) fluids where appropriate, if they were suffering from dehydration.

Children were prioritised where possible, 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 fully and accurately completed patients’ fluid and nutrition charts where needed. We saw fluid balance charts and nutrition charts were filled in appropriately and kept up to date. Neonatal feeding plans and feeding charts were reviewed and up to date, ensuring babies received age appropriate nutrition and hydration.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used 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. We saw these completed in patient records.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. 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.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients' 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."

On the NNU babies were given a sucrose (sugar) solution for pain relief when having procedures such as cannulation or heel pricks. A neonate’s pain tool was in use on the NNU. Premature babies were also given specialist soothers (dummies) for non-nutritive sucking. This helped soothe the babies if they were distressed and encouraged oral skills.

Patients received pain relief soon after requesting it. Parents and patients we spoke with told us they received pain relief quickly.

Staff prescribed, administered and recorded all pain relief accurately. Medicine charts we reviewed showed that pain relief was appropriately recorded.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed similarly to other hospitals in national clinical outcome audits and managers used the results to improve services further.

**Paediatric diabetes audit**

The table below summarises the trust’s performance in the 2016/17 National Paediatric Diabetes Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion rate for key health checks for patients aged 12+ (There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)</td>
<td>83.0%</td>
<td>Better than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted mean HbA1c (HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)</td>
<td>65.2</td>
<td>Better than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Median HbA1c (This measure is provided to give an indicator of how performance has changed between the previous and latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)</td>
<td>61.5</td>
<td>No clinically significant change</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Paediatric Diabetes Audit)
This showed that the department performed better than expected for two indicators and similar to other hospitals for one indicator.

National Neonatal Audit Programme

Lister Hospital

The table below summarises Lister Hospital’s performance in the 2018 National Neonatal Audit Programme (NNAP) against measures related to neonatal care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all babies &lt;32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc? (Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)</td>
<td>59.6%</td>
<td>Within expected range</td>
<td></td>
</tr>
<tr>
<td>Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? (Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)</td>
<td>92.4%</td>
<td>Better than expected</td>
<td></td>
</tr>
<tr>
<td>Do all babies &lt; 1501g or a gestational age of &lt; 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way)</td>
<td>98.0%</td>
<td>Within expected range</td>
<td></td>
</tr>
<tr>
<td>Do all babies with a gestation at birth &lt;30 weeks receive a documented follow-up at two years gestationally corrected age? (It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)</td>
<td>66.4%</td>
<td>Within expected range</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Neonatal Audit Programme)

During the inspection we asked if the department had an action plan in place to improve their scores for the NNAP audit. Senior staff were not aware that the new audit had been released and as such had not created an action plan at that time. We were told that once the team had reviewed the audit results they would create an action plan to work on areas for improvement.

Managers carried out a comprehensive audit programme. A local audit programme was in place, which included audits such as hand hygiene, PEWS and the matron’s checklist. This showed compliance was generally strong.
Managers used information from the audits to improve care and treatment. We saw that in areas which were highlighted for improvement, for action plans were created to improve these aspects of care.

There were engagement meetings and/or follow-up of audit outliers. Audits were repeated when areas for concern were identified.

Managers shared and made sure staff understood information from the audits. Audit results were shared at team meetings so that staff knew what areas they were doing well in, and which required further action. We saw this was evidenced through team meeting minutes.

Improvement was checked and monitored. Managers were aware of any audit outliers on their wards.

**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 and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Competency packs were developed to ensure that staff developed the skills and knowledge to undertake their roles safely and effectively. For example, there were competencies in NNU for health care support workers to work in the milk kitchen preparing feeds for babies. We spoke with a newly employed apprentice care support worker on Bluebell ward who told us that they were going through a variety of competencies under supervision of a more experienced colleague. Competencies included taking children’s blood pressure and taking children’s temperatures.

There were a variety of nurse champions. These were nurses with interests in specific areas, who championed their cause. Topics included mental health, learning disability, resuscitation, infection control, clinical governance and guidelines.

Managers made sure most staff received any specialist training for their role. Qualified in speciality (QIS) staff were employed within the NNU. QIS nurses are nurses who have completed additional studies approved by Health Education England. All nurses working in the high dependency unit (HDU) and intensive care unit (ICU) within the NNU were QIS qualified.

The NNU was not meeting their target for the number of nurses qualified in new born life support (NLS). This was raised at our last inspection, and since then, external funding had been sought to pay for staff training in NLS. Senior staff assured us that staff members were being booked into training and that they expected compliance by December 2019. This was on the risk register.

There was a medical lead, 12 paediatricians and four neonatologists. There was a team of anaesthetists who worked with the paediatric team and would see all children and young people who required anaesthetic. This ensured that they had the right skills and expertise and effective team working occurred.

Managers gave all new staff a full induction tailored to their role before they started work. All staff we spoke with confirmed they had a full induction when they started their role. This included both a corporate induction where they were told about trust values and expectations, as well as local inductions to the ward. Staff worked in a supernumerary role (not counted in the numbers) when they initially began.

**Appraisal rates**
Managers supported staff to develop through yearly, constructive appraisals of their work. From April 2018 to March 2019, 89.2% of staff within children’s services at the trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>2</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>6</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>121</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>43</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>206</td>
</tr>
</tbody>
</table>

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

Lister Hospital

From April 2018 to March 2019, 88.6% of staff within children’s services at Lister Hospital received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>2</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>6</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>109</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>28</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
There were enough clinical educators to support staff learning and development. Staff we spoke with were aware of who to go to in order to get support and development.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. If staff were unable to attend team meetings, minutes were sent to them via email and hard copies were left in the staff room.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that their personal development plans were discussed during appraisals and that they were given the opportunity to undertake additional training and courses. Senior staff told us that there was a strong culture of learning and development and that staff often came to them with ideas for further training. Secondments were also used. During our inspection we spoke with one ward manager who was currently on a secondment to a clinical governance role, to increase their knowledge in this area.

Student nurses from a local university undertook placements within the wards. Course tutors from the university visited the students to assess their competencies.

The service had recently introduced registered nurse associates. These were new members of the nursing team in England. The role is designed to help bridge the gap between health and care assistants and registered nurses.

Nurses with interests in particular areas, for example, infection control or safeguarding, had the opportunity to become link nurses. These were nurses who liaised with specialist teams and would provide advice to staff and share information.

The safeguarding team had close links with the local police force and social services. They arranged for guest speakers to come in and provide training sessions to staff on areas such as child sexual exploitation (CSE) and county lines (drug trafficking).

Junior medical staff told us that they were given the opportunity to undertake ongoing educational development. This was reflected in the most recent General Medical Council (GMC) report which showed higher levels of junior doctor satisfaction. This was an improvement from the previous inspection. The department had also introduced the ‘trainee of the month’ whereby one junior doctor each month was highlighted and celebrated.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us that areas of poor performance were identified through audits, following incidents and during appraisals. We saw that following a serious incident (SI) involving a medication error, the staff involved went on refresher medication administration training.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. Daily handovers were attended by the MDT. The handover we observed on the NNU was attended by medical staff, nursing staff, a psychologist and the family liaison nurse. The safeguarding team also hosted MDT psychosocial meetings every two weeks. These were attended by medical staff, nursing staff, the safeguarding team and external bodies such as health visitors, school nurses and social services.
MDT huddles were held four times a day in ED and three times a day on the wards. These were attended by a variety of staff including allied health professionals.

Staff worked across health care disciplines and with other agencies when required to care for patients. The safeguarding team had regular meetings and case reviews with the police and social services. Joint meetings were also held with the local CAHMS team and the community nursing team. When children were identified as requiring assistance from physiotherapy or speech and language therapists, appropriate referrals and liaison were made.

Staff we spoke with confirmed that there was positive MDT working across the department, with limited concerns regarding hierarchy.

The paediatric department had a dedicated pharmacist lead, who provided the wards with assistance regarding medication. The pharmacist visited the wards often and we saw them on the wards during our inspection.

The play team were available to help children understand their condition and relax them through play. They also attended adult wards such as palliative care wards or the critical care unit, to assist children whose parents were acutely unwell or dying. During our inspection we saw they attended the critical care unit and helped a child whose parent’s life support was being withdrawn.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.44 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We saw evidence that children were referred for CAHMS assessments when required. 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.

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 from the age of 14 before the child moved to adult services. We were also told of a transgender child who was beginning to transition to adult services and the efforts the team had gone to, to ensure they felt supported during the transition. Once the child was 16 years old they were given the option of continuing on the children’s ward or being seen by the adult team.

Seven-day services

Key services were available seven days a week to support timely care for children, young people and their families.

Bluebell ward, the NNU, the paediatric emergency department and the children’s assessment 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.

The play specialists provided a seven-day service, with hours of operation of 7.30am to 9.30pm.
Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Following ward rounds consultants went home but remained on call and would come in as and when needed. 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 8.30am a consultant was on-call. At weekends consultants were on site for the morning ward round then on call from home.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Mental health services were available seven days a week, through a mixture of CAHMS and RAID.

Diagnostic services for example X-ray, ultrasound and computed tomography (CT) scanning were available 24 hours a day, seven days a week. From 9pm to 9am images results were reported off site by an external provider and we were told there was no delay in reporting. Between 9am 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.

Dietitians, occupational therapists and speech and language therapists were not available at weekends.

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.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Posters were displayed in the corridor leading to both Bluebell ward and Bramble ward which outlined the importance of healthy sleep habits and reducing electronic screen time. We also saw posters outlining the importance of healthy self-esteem and signposts to services which could help children develop confidence in themselves.

Information was available on the NNU about the health benefits of breastfeeding and leaflets were available within the expressing rooms for fathers explaining how to support breastfeeding mothers and how to bond with their baby.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Measurements such as height and weight were taken so that children’s body mass index (BMI) could be assessed so that parents could be given advice on healthy eating if required.

All staff were offered the influenza (flu) vaccination to reduce the risk of contracting flu. The final uptake figure for the flu vaccination campaign 2018/19 trust wide was 65.6%. 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, passing it on to colleagues and patients and be unavailable for work.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff we spoke with were aware of how to assess a young person’s capacity to consent and explained that they would refer to a manager or the safeguarding team if they were unsure.

Staff made sure children, young people and their families consented to treatment based on all the information available. We saw that children and their families were given information about their care plan, with the risks and benefits of treatment options, so that they knew what they were agreeing to.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Staff provided examples of how children’s cultures could impact on their clinical care and how this would be taken into account.

Staff clearly recorded consent in the children and young peoples’ records. The records we reviewed showed that consent was recorded appropriately.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Both medical and nursing staff we spoke with were aware of Gillick competence (whereby a mature teenager can consent to treatment if they understand the proposed treatment correctly) and Fraser guidelines (for access to contraception and sexual health).

Mental Capacity Act and Deprivation of Liberty training completion

Trust level

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at trust level for registered nurses in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>146</td>
</tr>
</tbody>
</table>
In children’s services the target was met for both MCA/DOLS training modules for which registered nurses were eligible.

Clinical staff did not all complete training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>28</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>29</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for both MCA/DOLS training modules for which medical staff were eligible.

During the inspection we were told that the data provided in the table above was incorrect. We received data which showed that medical staff had 100% compliance in safeguarding training.

**Lister Hospital**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at Lister Hospital for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>121</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>121</td>
</tr>
</tbody>
</table>

In children’s services the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Lister Hospital for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>34</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>33</td>
</tr>
</tbody>
</table>

In children’s services the target was not met for both MCA/DOLS training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Other CQC Survey Data

CQC Children and Young People’s Survey 2016 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 three questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

CQC Children’s Survey questions, effective domain, East and North Hertfordshire NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<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>9</td>
<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>19</td>
<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>33</td>
<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>54</td>
<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)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke with were aware of the laws governing consent to treatment. They explained that if they were unsure about a child or young person they would speak to the safeguarding team for advice.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Parents and young people that we spoke with confirmed that staff gained their consent before all treatments and procedures. Verbal consent was obtained for procedures such as observations or blood tests. Written consent was obtained for more invasive procedures such as surgery.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The policy was available on the intranet which all staff had access to.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.
Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff responding promptly to children and their families when they requested assistance. We observed positive interactions and staff playing with children to put them at ease.

Children, young people and their families said staff treated them well and with kindness. All children, young people and their parents that we spoke with, said that the staff treated them with compassion. One parent noted that the nursing staff on Bluebell ward were especially empathetic to her, as her child was a regular attendee on the ward.

Staff followed policy to keep care and treatment confidential. Staff ensured that handovers were held in confidential locations to avoid people overhearing private information. On the neonatal ward (NNU), staff had recently introduced ear cancelling headphones that parents could wear during ward rounds, so that they did not hear about other babies, but also did not have to go out of the room and leave their baby.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Staff we spoke with explained how they cared for children or young people with mental health needs. They explained that they used the sensory room located within the play room on Bluebell ward, if the child or young person was feeling overwhelmed and needed a quiet place to calm down.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff explained that children’s cultural or religious needs could impact on the food they wanted to eat and how they would ensure their needs were met. The hospital’s chaplaincy was available to attend the ward if children or their parents needed spiritual guidance.

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 Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<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>14</td>
<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>
</tbody>
</table>
Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff provided us with examples of times when they had helped children or their families when they were worried or anxious. Play staff actively sought to relieve children’s distress and were in use around the hospital. They accompanied children and young people to the operating theatre if they were concerned about undergoing surgery. During our inspection we also saw play staff attending to an adult palliative (end of life care) ward to support a child whose parent’s life support was being removed.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were aware of the importance of maintaining children and young people’s privacy and dignity. They explained how they would try to diffuse distressing situations by distracting the child if possible and moving them to a private place if needed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The family support nurse on the NNU provided emotional support to families when babies were acutely unwell and dying. They used a booklet to talk about the death to the baby’s siblings. A pathway was in place with the local children’s hospice. When babies died on the NNU the family support nurse assisted the parents with making memory boxes of their baby.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their family’s, wellbeing. Staff were aware of the impact of having a child with health needs and were sensitive to this. Within the NNU there was a family liaison nurse...
whose role was to support parents and family members deal with having a baby born prematurely or with health needs. There was a parents’ support group in the NNU where parents of unwell babies could meet and share experiences. Monthly coffee mornings where held to encourage parents to socialise and connect with each other. On Bluebell ward the play team had arranged for the parents of two children with a rare illness to meet up to share their experiences of caring for a child with a rare disease. The play team had also booked out a local soft play centre and invited children suffering with cancer to come and play whilst their parents made links with other parents in a similar situation. This was beneficial to both the parents who connected to each other and to the children, who ordinarily would have been unable to attend soft play during opening hours due to infection control reasons.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for the 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 Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<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>29</td>
<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>45</td>
<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>65</td>
<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>67</td>
<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 supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Children and parents we spoke with told us that staff explained their condition and treatment plans clearly and gave plenty of time for them to ask questions.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Information was given in easy to read formats, with staff
explaining them, so that children and young people could be equal partners in their care. Communication aids were available for children who were non-verbal.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw comment card boxes available on the wards and there were parent forums where parents gave feedback on the development of services. The service had recently introduced using patients on interview panels when interviewing prospective staff. We were told of an example when a child living with chronic fatigue syndrome was on the interview panel for the recruitment of a chronic fatigue nurse.

Staff supported children, young people and their families to make informed decisions about their care. Children and parents were given time to think about their decisions and information on the risks and benefits of the proposed treatment plans so that they could make informed decisions. Young people aged 16 and 17 years old were given the choice of whether they wished to be cared for on Bluebell ward or on an adult ward.

Friends and Family Test data was unavailable at the time of our inspection.

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 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016 that was relevant to the trust.

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 Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<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>12</td>
<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>13</td>
<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>15</td>
<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>16</td>
<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>17</td>
<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>18</td>
<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>Question</td>
<td>Age Group</td>
<td>Score</td>
<td>Comparison</td>
<td>Code</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
<td>------------</td>
<td>------</td>
<td></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>
<td></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>
<td></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>
<td></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>
<td></td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.44</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>9.02</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>8.21</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.03</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.54</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>5.82</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 CYP</td>
<td>9.19</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 CYP</td>
<td>8.83</td>
<td>About the same as other trusts</td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 CYP</td>
<td>7.10</td>
<td>Worse than other trusts</td>
<td>C2</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Bluebell ward flexed their number of beds depending on the patient acuity (number of patients and their medical requirements). During the summer months the ward planned for 16 beds, with this rising to 20 beds in the winter, to account for winter pressures.

To meet increased demand over the winter months, an additional registrar had been employed for night shifts on the children’s assessment unit during the winter.

The department had recently audited their caseload of jaundiced babies attending the children’s assessment unit (CAU). This found that health visitors and community midwives from Bedfordshire did not have the correct equipment to test babies for jaundice in the community. As such, there was an influx of babies coming into the CAU from Bedfordshire for jaundice that could have been treated in the community. The CAU team spoke with the local clinical commissioning group (CCG) and advised them to buy non-invasive jaundice tests. This resulted in more babies being able to be tested and treated at home in the community.

A nurse led constipation clinic had recently been introduced. It had found that this had reduced outpatient attendances by 30%.

Facilities and premises were appropriate for the services being delivered. Bluebell ward had separate bays where younger children could be cared for with their parents or that could be used 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, during our inspection we saw a very young baby in a side room on Bluebell ward. Every bed on Bluebell ward had space for a camp bed so that each child could have one parent stay with them if needed.

On the neonatal unit (NNU) there were two single and two double “rooming in rooms” for parents to be able to stay overnight with their babies. This helped parents get used to caring for their babies directly before being discharged. There was also a parents’ lounge which parents could use to make hot drinks. Charitable fundraising was occurring at the time of our inspection to raise funds to expand the parents’ lounge.

The Bramble suite which was used to examine and interview children and young people following alleged physical abuse or neglect was private and child friendly. Bramble ward held a variety of outpatient clinics. GPs, 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 area contained a variety of age appropriate toys, books and DVD’s.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. Children and adolescent mental health services (CAHMS) was provided by a different trust, which the department had a service level agreement with. CAHMS staff were available during the day. Outside of these hours staff accessed emergency mental health support via the rapid, assessment, interface, discharge (RAID) team.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Arrangements were in place for
young people who were transitioning from paediatric care to adult services. Transition arrangements began when a child was 14, whereby joint clinics were held with both paediatric and adult consultants in attendance. During the course of these clinics young people were empowered to take charge of their health decisions so that once they were 16 years old, they were confident in managing their health needs with the staff. Transition clinics were held four to six times a year, depending on speciality. Specialities that held transition clinics included diabetes, neurology and attention deficit hyperactive disorder (ADHD) among others.

Managers monitored and took action to minimise missed appointments. Staff told us that they monitored the rates of children not being brought to outpatient appointments. If a child missed their appointment staff liaised with their health visitor and school nurse to assess if there were any safeguarding concerns.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Phone calls and letters were sent to the families of children who did not attend outpatient appointments. Contact was also made with the child’s referring organisation, for example, their GP.

The service relieved pressure on other departments when they could treat children and young people in a day. During our inspection we observed a bed meeting where representatives of all divisions attended to discuss bed pressures. We saw staff from the paediatric division offer to take two young people who were aged between 16 and 17 years old, in order to reduce pressures on other wards. We saw an assessment was undertaken to see if the young people were appropriate to be on a children’s ward, both for their comfort and the comfort and safety of the other children on the ward.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for the 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 Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<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>5</td>
<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>25</td>
<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>26</td>
<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>28</td>
<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>Question</td>
<td>Age Group</td>
<td>Score</td>
<td>Comparison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
<td>------------</td>
<td></td>
<td></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></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.31</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.39</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.68</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.71</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.53</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.49</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>8.66</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>4.12</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Meeting people’s individual needs**

The service was inclusive and took account of children, young people and their families individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. 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. 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. We saw these being used for a CAHMS patient during our inspection.

Wards were designed to meet the needs of children, young people and their families. The entrance to Bluebell ward and Bramble ward had murals painted both on the walls and on the ceiling, so that children being wheeled to theatres had something to look at. A mural was also painted in the corridor to the NNU with the names of babies who had been cared for on the unit, who had then raised money for the mural. Toilets were designed for children of all ages, with some equipped for smaller children and others listed as teenage toilets.

There was a large playroom connected to Bluebell ward. There was a wide range of toys for all age groups. A separate room was available for teenagers with sofas, a television and a games console. There was another room specifically reserved for oncology patients, and one for children requiring sensory input. 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.

Staff used transition plans to support young people moving on to adult services. This is described under service planning.

Staff supported children and young people living with complex health care needs by using care passports. This allowed staff to be kept up to date with the child's condition without parents having to keep repeating themselves to multiple members of staff.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff were aware of policies detailing how to communicate with children with a disability or sensory loss. They were able to describe different ways that they would communicate with children in their care, including play.

The service had minimal information leaflets available in languages spoken by the children, young people, their families and local community. All information leaflets we saw were written in English, with none readily available in other languages. Additionally, many of these were out of date, which we also found on our last inspection. We saw one leaflet which was written as a magazine, in child friendly language with illustrations to show how a child would be cannulated (the insertion of a small tube into a vein, often to administer intravenous (IV) fluids or medication).

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Translation services were provided by an external company. Staff could request telephone interpreting or face to face.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Food menus had options for children who followed halal, kosher, vegetarian and vegan diets.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Staff were aware of how different children had different communication needs. Some staff were trained in Makaton (a language programme designed to provide a means of communication to individuals who cannot communicate efficiently by speaking). Makaton uses hand gestures like sign language but is not a language and is designed to be used in conjunction with the spoken word. We saw ‘you said, we did’ posters displayed on Bluebell ward stating that they would like more staff to be trained in Makaton. The service said it was looking at options to train more staff in Makaton. Boards on the NNU showed that parents had previously said they did not understand all the equipment used on the NNU. To improve this an equipment board was displayed which explained what all the various equipment was used for.
A new initiative was started in November 2018 where parents on the neonatal unit were provided with charitable funded noise reducing headphones during ward rounds. This was to allow them to block out the sounds of the ward and focus on bonding with their new born baby, whilst also providing confidentiality to other parents and babies.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

**Neonatal Critical Care Bed Occupancy**

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The average length of stay on Bluebell ward was two days. Length of stay on the NNU varied between a few days to several months, depending on the prematurity and health needs of the baby.

Blood cultures were taken off site to be reviewed. If the cultures tested positive, then the laboratory would phone the hospital to alert them. If the children were well enough they would be sent home, therefore waiting for blood results did not delay discharge. The department discharged patients with prophylactic antibiotics and if the results were negative (no infection) then the parent was called to inform them that the child did not need to continue with the treatment.

From May 2018 to April 2019, the trust saw neonatal bed occupancy fluctuate month on month with no clear trend. Caution should be taken when interpreting the chart below due to a low number of neonatal critical care beds at the trust (10 beds available in all months other than July 2018 where there were 11 available beds).

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Managers monitored waiting times but children, young people and their families did not always access services when needed and receive treatment within agreed timeframes and national
targets. 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 publicly report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter.

The RTT figures for June and July 2019 were 84% and 81% respectively for non-admitted (outpatient) appointments, which was below the target of 90%. As of July 2019, 203 children and young people were waiting over 18 weeks for an appointment. Harm reviews were conducted when patients waited over 40 weeks for an outpatient appointment. We were told these had found no harms had occurred. In order to improve RTT the department had employed two part time hybrid consultants to offer additional clinics and was recruiting an additional substantive consultant. At the time of our inspection there were no children waiting over 52 weeks for appointments.

Rapid access clinics were held three times a week and helped to bring waiting lists down. GPs had a hotline five days a week for four hours a day, when they had direct access to consultants for advice. This allowed patients to be streamlined so as to avoid sending unnecessary patients to ED.

The NNU had weekly meetings with the maternity department to assess any known incoming babies and discuss ways to reduce full term admissions. Examples of practice introduced as a result of these were staff giving antibiotics to babies on the postnatal ward and changing the times of elective caesarean sections to avoid out of hours procedures.

Managers monitored waiting times and made sure children, young people and their families could access emergency services when needed and received treatment within agreed timeframes and national targets. The service had introduced a paediatric decision unit (PDU) within the minor injury area of children’s ED. This provided additional assessment capacity. All children who were sent to the PDU had already been seen by a doctor and had a plan of care and were awaiting review by a speciality team. Children were referred to the PDU from GP practices in the community or ED. Data showed that this had increased patient flow through the department and that children’s ED performance had achieved higher than the 95% target for the previous 16 months. This accomplishment led to the team being asked to present their method at a Royal College of Paediatrics and Child Health conference.

At our last inspection we found that waiting times on the CAU were not monitored. We requested data on waiting times during this inspection and were provided with one audit. It showed that between 10am and 10pm 19 children were seen by a senior house officer (SHO) within one hour, two children waited for up to two hours, two children waited for up to three hours, four children waited for up to four hours and one child waited longer than four hours. From 10pm to 10am the audit indicated that nine children were seen within one hour, and one child was seen within two hours.

The CAU also audited the length of time between seeing an SHO and seeing a registrar. This showed that 14 children waited less than an hour between seeing an SHO and a registrar, seven children waited up to two hours, one child waited up to three hours, three children waited up to four hours and three children waited longer than four hours.

Managers did not always manage to keep the number of cancelled appointments at a minimum. In the three months prior to our inspection 736 outpatient appointments were cancelled. Of these, 310 appointments were cancelled by the hospital.
When children and young people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that when the hospital cancelled the appointment they were booked onto the next available appointment. If the patient was marked as urgent then staff looked at whether they should be moved to a different consultant with a shorter waiting list.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff we spoke with explained how discharge planning began as soon as a baby or child was admitted. We saw on the NNU that a roadmap to discharge was displayed. This outlined the approximate length of stay a baby was planned to have on NNU depending on the age of gestation (how far along in the mother’s pregnancy) they were when they were born. Staff explained they highlighted this to parents but explained that additional needs could delay the baby’s discharge further, and that it was a guide, not a defined timescale.

Staff planned children and young peoples’ discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured that appropriate referrals for ongoing care had been made and that parents knew the contact details of the community nursing team.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Since the introduction of an electronic discharge system in 2017, there had been delays sending discharge letters. The position had improved since our last inspection, however, there were still approximately 120 delayed discharge letters on the system. We were told some of these had been sent but the system did not display this data, and that others had not been sent due to user error with the system.

To improve the position on discharge summaries, each day a doctor on the children’s assessment unit was ringfenced from 12pm to 2pm to work solely on discharge summaries. It was projected that the service would be up to date on discharge summaries by the end of August 2019.

The department had recently introduced a trial of criteria led discharges. This meant that children were discharged once they met certain criterion and both advanced nurse practitioners and doctors could assess against the criteria. This trial had been ongoing for three months at the time of our inspection. It was thought this would reduce delayed discharges as children would not have to wait to see a doctor.

Staff supported children, young people and their families when they were referred or transferred between services. Staff we spoke explained how transfers could be difficult for children and their families and the steps they took to put them at ease.

Managers monitored patient transfers and followed national standards. Children with very complex needs were referred to other nearby NHS hospitals. We saw suitable arrangements were in place regarding the transfers.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, complaints were not always answered within the trust’s target.

Summary of complaints

Children, young people and their families knew how to complain or raise concerns. Parents we spoke with said they would raise concerns with nursing or medical staff on duty, if they had cause for concern.
The service clearly displayed information about how to raise a concern in patient areas. We saw posters displayed on ward areas that highlighted the patient advice and liaison service (PALS), where parents or children could raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of the complaints policy and knew how to escalate complaints so that they were dealt with appropriately.

Managers investigated complaints and identified themes.

**Trust level**

From April 2018 to March 2019 the trust received 45 complaints in relation to children’s services at the trust (4.6% of total complaints received by the trust). The trust took an average of 53.6 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed within 35 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times</td>
<td>20</td>
<td>44.4%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>11</td>
<td>24.4%</td>
</tr>
<tr>
<td>Communications</td>
<td>9</td>
<td>20.0%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>4</td>
<td>8.9%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From April 2018 to March 2019 there were three compliments about children’s services at the trust. All three compliments were received by Bluebell Ward at Lister Hospital (6.4% of all received trust wide).

The trust stated that compliments are received via the CEO office, these were responded to and sent to the relevant areas by the CEO. They are then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust is currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

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

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Staff we spoke with told us what they would do if a patient or parent complained to them and how this would be escalated. We saw that families received letters detailing the outcome of their complaint.
Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback and learning from complaints was shared at team meetings. We also saw ‘you said, we did’ feedback boards on the wards.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

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, the matron and a non-executive director. The children’s service was part of the women’s and children’s division. The children’s and young people’s services included inpatient and outpatient services. Two weeks prior to our inspection the division joined with the surgical division to become part of planned care. Paediatrics still had their own separate board, which then fed into the planned care board. This, in conjunction with having an ear, nose and throat (ENT) surgeon sitting on the board as the paediatric surgical lead for the trust, ensured that the children’s division still had a voice on the planned care board.

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.

All staff spoke very positively about the matrons and the ward sisters. Staff described them as supportive and approachable.

Photographs of senior leadership were displayed on the wards but not all staff said they would recognise them if they visited.

A leadership programme was in place, which helped staff wishing to develop their leadership skills and careers.

A yearly away day was held which all staff band 7 and above were invited to. This included both clinical and administrative staff. It focused on staff working better together.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

A new trust wide vision was launched in 2019. This was ‘proud to deliver high quality, compassionate care to our community’. This incorporated five strategic priorities. These were sustainability, people, pathways, ease of use and quality. The strategic priorities were designed and developed through a series of workshops that staff groups attended. Posters were displayed on the ward explaining how the strategy was important to their work. This explained how quality had led to opening the paediatric decision unit (PDU), people had led to introducing registered nursing associates (RNA), and pathways had led to piloting criteria led discharges.
The values were called PIVOT, ‘patients first, continuous improvement, value all, open and honest and work as a team’.

Staff we spoke with were aware of PIVOT and what it meant for their jobs.

**Culture**

**Staff felt respected, supported and valued.** They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff we spoke with told us there was a good culture with teams working well together and management listening to concerns raised. One consultant told us they felt that they were not listened to when they raised concerns but all other staff we spoke with were happy with the service.

There were opportunities and support for staff development. Staff told us they were empowered to seek out development opportunities, both internally and externally, and that they were supported by managers to take these up. During our inspection we spoke with staff who were undertaking secondments to other roles.

Most staff we spoke with knew who the freedom to speak up guardian was. This was an improvement from our last inspection when no staff could tell us who it was.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations.** Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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. 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. We saw that staffing including vacancy and sickness levels, appraisals and mandatory training were reviewed. Referral to treatment times (RTT) times were also discussed.

Monthly clinical governance meetings were held, minutes of these meetings were circulated to staff. Staff were aware of these meetings and there was involvement from trainee doctors in the updating and development of guidelines. Staff also used a mobile messaging service to alert staff to any new clinical governance issues. Approximately 50 doctors were in the messaging group and this alerted them to any incidents and also the governance ‘messages of the week’.

We reviewed the quarterly clinical governance newsletter. This was shared to all staff to alert them to clinical governance issues and recent incidents. We saw it highlighted a recent incident where a baby swallowed a button battery. Learning from this incident regarding the urgency of ear, nose
and throat (ENT) referrals was shared on the newsletter. It also included a section on recently updated guidelines and learning from complaints.

Paediatric and surgical meetings happened monthly. All incidents, including those that were serious and risk registers were considered.

The service had recently appointed a second clinical director. There was one clinical director (CD) for acute and one for neonates. Prior to this one CD covered both. This was seen as a positive change by staff.

The CYP department had had several peer reviews including the neonatal and paediatric oncology service reviews. During our inspection the neonatal peer review was conducted. Positive feedback had been received and the areas highlighted for improvement were already known to the staff.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

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. The risk register was comprehensive. Each risk had a date added, a risk owner, a risk level and evidence of ongoing monitoring. There were 26 risks on the risk register, eight for the neonatal unit (NNU), two for the emergency department (ED), and the rest general paediatrics and surgery. Risks included ageing and/or insufficient equipment, staffing concerns, and referral to treatment (RTT) times. We saw that funding was being sought for more equipment and staff and that locums were employed. Additionally, children waiting over 18 weeks were given the first available appointment.

At our last inspection we saw that the backlog of discharge letters and the security of the paediatric wards were not listed on the risk register. We saw that they were on the risk register this time, with mitigating actions in place.

Risks were discussed at paediatric and neonatal safety huddles which were held twice a day.

Plans were in place to cope with unexpected events. During our inspection the electronic observation system stopped working. Staff changed to using paper charts to note patients’ observations with limited impact on children or young people.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

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 had been issues with user error. This had led to discharge summaries being delayed and not sent out, and cases whereby
summaries had been sent but the system did not recognise it. We were told further training was ongoing to ensure staff knew how to operate the system correctly.

The electronic system had inbuilt systems to identify children at risk of abuse. Children with mental ill health could also be identified through the system.

There were arrangements in place which ensured data was submitted to external providers as required for example, serious incidents and never events.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

A corporate engagement strategy had been in place from 2016 to 2019. This outlined the trust’s vision ‘to be among the best’. There was no specific engagement strategy for children’s and young people’s services.

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. 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. One of the registered nurse associates on the NNU had won an award for their work on patient experience.

The trust had a children’s and young people’s forum where patient views were 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 sought and they were encouraged to participate in patient and parent forums.

Staff meetings were held regularly and well-attended. Staff were given minutes of the meetings if they were unable to attend.

The department had strong engagement with the local community, both primary care and the local clinical commissioning group (CCG). GPs had a hotline five days a week for four hours a day, when they had direct access to consultants for advice. Consultants also provided email advice to GPs.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

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. This had been ongoing since the last inspection.

Since the introduction of the paediatric decision unit the children’s emergency department had met the four-hour target for the previous 16 months.
End of life care

Facts and data about this service

The trust provides end of life care at Lister Hospital and the Mount Vernon Cancer Centre. End of life care encompasses all care given to patients who have been identified as having entered the last 12 months of their life or less. Care is provided to all wards within all service throughout the trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support, and mortuary services.

End of life care at the trust is not provided by one service alone but is a trust-wide responsibility. The specialist palliative care team within cancer division support end of life care throughout the trust, targeting the areas of most need by providing education, raising awareness, and supporting the patient throughout their journey. The team include an end of life care education team, specialist nurses running a 7-day service, and consultant cover which is a joint appointment with the community (Isobel hospice) allowing the trust to collaborate more closely with the community.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 1,501 deaths from February 2018 to January 2019.

(Source: Hospital Episode Statistics)

We completed an announced inspection of the end of life care service on 23, 24 and 25 July 2019. This report refers to the inspection of end of life care at Lister Hospital. The inspection mainly considered patients whose death was imminent (expected within a few hours or days). It included those approaching the end of life and were likely to die within the next 12 months irrespective of underlying diagnosis. We inspected do not attempt cardio pulmonary resuscitation (DNACPR) forms, drug charts, checklists and nursing care records.

During our inspection we looked at end of life care for adults and visited various wards at Lister Hospital where patients received end of life care. We spoke to a representative sample of most teams involved in end of life care: bereavement team, chaplaincy, clinical director for end of life care, administrative staff, a palliative care consultant, clinical nurse specialists, end of life care discharge coordinators, end of life care champions, clinical support workers, mortuary staff, pharmacist, registered nurses and ward clerk. We observed interactions between the staff and patients and relatives in their care. We looked at policies and procedures and reviewed performance information about the care patients received at the end of their life at the trust.

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 made sure everyone completed it.

Mandatory training completion rates

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

Staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in end of life care is shown below:

Trust level

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>14</td>
<td>14</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90%</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 98.4% for qualified nursing staff in end of life care.

It should be noted that the data for nursing staff refers to 16 eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

Lister Hospital

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the end of life care service at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
</tr>
</tbody>
</table>
At Lister Hospital there was an overall training compliance rate of 100% for qualified nursing staff in end of life care. The trust’s training target was exceeded in all eight mandatory training modules for which qualified nursing staff were eligible.

There was an improvement in the reporting of mandatory training compliance. At our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, the trust did not provide mandatory training compliance for nursing staff working within the end of life care service at Lister hospital. The trust provided trust-wide mandatory training compliance as at July 2015, and 88% of eligible staff had completed required training. This was near to the trust 90% trust target. During this inspection, data was provided for nurses working directly within the service at Lister hospital which demonstrated improved oversight of training completion.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>1</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>1</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>1</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>1</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>1</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>0</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)
The trust had an overall training compliance rate of 71.4% for medical staff in end of life care at trust wide level. The trust’s target was met for five of the seven mandatory training modules for which medical staff were eligible.

Following our inspection, the trust confirmed mandatory training for locum consultants was overseen by their own agency and confirmed there was 100% compliance as at November 2018.

The mandatory training was comprehensive and met the needs of patients and staff. 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. Staff told us the training was comprehensive and supported the provision of safe patient care.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. For example, many staff had completed a dementia awareness course that provided healthcare professionals with the tools to support patients facing challenges from diagnosis to end of life care. Some staff had completed a course about supporting patients with mental health and palliative care needs, and clinical nurse specialists (CNSs) completed communication skills workshops or advanced training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us training was discussed in team meetings and that they received reminders and were allocated time to complete required training.

The trust employed a palliative lecturer practitioner who coordinated education in the trust. A clinical practice educator role, which had remained vacant for much of 2018, focused on delivering targeted, specific training sessions in relation to end of life care to staff working on the wards. Due to the vacancy, specific ward-based training and the up-skilling of end of life care link nurses/champions had significantly reduced during the second half of 2018/9. At the October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, end of life care training was included in the trust's mandatory training. During this inspection end of life care training was not mandatory however, there were plans to reintroduce it as a mandatory subject during 2019. It was aimed that an e-learning package for newly qualified nurses would become part of their mandatory training going forward. Whilst we observed this was a ‘rolling’ agenda item in the end of life care steering group minutes, there was no confirmed date for its reinstatement. The training was discussed at the April 2019 steering group meeting, and no progress was evident three months later at the July 2019 meeting.

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 set a target of 90% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training was mandatory for all staff, the level of which was dependent on the role. For example, administration staff that did not have contact with children or adult patients were required to complete awareness training only. Staff that had contact with patients were required to complete safeguarding children level 2 and safeguarding adult’s level 2.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in end of life care is shown below:
## Trust level

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

The 90% trust target was met for all eligible registered nursing staff.

### Lister Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the end of life care service at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

At Lister Hospital the 90% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
In end of life care service, data provided by the trust prior to our inspection confirmed that the trust target was not met by medical staff for any of the four safeguarding training modules. Following our inspection, the trust confirmed that palliative consultants (one whole time equivalent) were locums and mandatory training was overseen by their respective agencies. The hospital confirmed following our inspection there was 100% compliance with safeguarding children and adults' level 2/3 training.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff we spoke with had not been required to make a safeguarding adult referral however, they understood that safeguarding adults was a fundamental part of patient safety and wellbeing. They were able to provide examples of when they would make a safeguarding referral if they were concerned that a vulnerable patient was unable to protect themselves against significant harm or exploitation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust investigated adult safeguarding concerns in collaboration with the patients’ local authority. All safeguarding concerns were shared with the local county council to support patients’ safety. The trust liaised with the relevant external agencies, including representation at the Safeguarding Adults Board, and had internal processes for the regular review of safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. For example, one nurse told us they had made a safeguarding report when there were concerns for a patient’s children’s welfare when they had been hospitalised. Less experienced staff told us they were confident in seeking support from a more senior nurse, or safeguarding link nurse to ensure concerns were recognised and reported as required. Patients who had a potential or identified safeguarding concern were discussed in nurse ‘huddles’/ward rounds daily.

Staff were familiar with the safeguarding policy and could locate policies and safeguarding information in their individual areas of work and on the intranet. They were able to identify patients at risk of harm.

Staff followed safe procedures for children visiting the ward. Prevent awareness, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, was included as part of the safeguarding training. Female Genital Mutilation (FGM) was also included in level two safeguarding training, which all clinical staff completed. Staff were aware that they had a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who had given birth to a female infant. Child Sex Exploitation (CSE) was included in level two and three safeguarding training. CSE is a form of child abuse and reportable to children’s social services in line with safeguarding procedures. Staff were aware of the potential indicators of abuse however, had not been required to raise a referral. The trust policy for safeguarding children included FGM and CSE.
Leaflets on safeguarding adults at risk from the local safeguarding adults board were readily available. They detailed what types of abuse there were, what behaviour to look for, and contact details to report the abuse.

**Cleanliness, infection control and hygiene**

**Staff used infection control measures when visiting patients on wards and transporting patients after death.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. For example, all areas we visited including wards, patient visiting rooms, and the viewing suite in the mortuary complex were visibly clean, tidy and mostly well maintained. At the time of the October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, the flooring in the post mortem room, despite being cleaned regularly, was stained and in a poor state of repair. During this inspection, the floor remained in a poor state of repair however, it was cleaned regularly.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. An infection prevention and control audit of the mortuary environment was completed in May 2019 with an overall rating of 96.7%. The results found that the general environment and patient care space were visibly clean, with clean floors, furniture and sinks.

Staff followed infection control principles including the use of personal protective equipment (PPE). Trust infection control guidelines were up-to-date, reflected national guidance and were available on the intranet. Guidance was available to reduce the risk of spreading an infection when providing care for patients after death. We saw examples of this documented in the trust’s mortuary policy which included the wearing of gloves, aprons and the use of body bags. There was a standard of practice document for the receipt of bodies (suspected infection), on the intranet and in the mortuary. Porters used gloves and gowns when transferring a deceased person from the bed to the trolley in the wards. PPE was then removed during transit and if necessary worn again on arrival at the mortuary. Ward and departmental staff wore clean uniforms. PPE, including gloves and aprons, was available for use by staff in all relevant areas.

There were enough hand wash basins, liquid soap, paper towels, hand gels and protective equipment available. We observed staff following hand washing procedures and using hand gels and the protective equipment available. Staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand washing and minimise the risk of contamination. We observed staff following NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

The trust had a 95% target for compliance with hand hygiene protocols. A trust-wide audit showed 81.7% compliance in January 2019, which demonstrated a deterioration from 94.2% compliance in January 2018. To improve compliance, hand hygiene information was displayed on wards and in corridors and staff were reminded in team meetings.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Throughout the inpatient wards, equipment was labelled with ‘I am clean’, dated stickers. Porters were responsible for cleaning the trolley used following a patient’s death. We were
assured that the trolley was cleaned following each patient transfer. We noted that the trolley was maintained and the wipeable cover over the trolley was kept in good condition, with no obvious tears.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed care to patients at the end of their life and saw they could reach call bells with ease. Patients and relatives told us staff responded quickly when called.

The design of the environment followed national guidance. There were enough spaces available in the mortuary, and refrigeration was suitable for the needs of the service. Staff told us these facilities were usually enough to meet the needs of the hospital and local population. The mortuary had an arrangement with a local funeral director which would allow for a further storage of 20 bodies in the event of an incident, if more facilities were required. The mortuary fridges were locked, and keys were held in secure locations. An alarm sounded if the fridge temperatures dropped below the required temperature. Faults on the fridges were alerted through the hospital switchboard to the mortuary and maintenance teams, who were available 24 hours a day to respond to any problems.

The setting surrounding the mortuary was tidy. The mortuary had a secure entrance and CCTV equipment to prevent inadvertent or inappropriate admission to the area. The inside of the mortuary was visibly clean and uncluttered.

The post mortem tables met the standards set by HBN20 Facilities for mortuary and post-mortem room services. A review of the mortuary services completed by a mortuary and bereavement manager from a local NHS trust in March 2019, highlighted that the post mortem room was 'small and dated' which meant movement in the area could have been difficult.

Staff carried out daily safety checks of specialist equipment. The maintenance of equipment supported staff to keep people safe. Staff had access to syringe drivers to provide end of life patients with anticipatory medication. A syringe driver is a small, portable, battery powered infusion device which is suitable for patient use in the hospital and at home and is used for delivering measured doses of pain medication. The trust used syringe drivers that met national safety standards and there was a planned maintenance schedule to ensure that syringe drivers were serviced. We reviewed two syringe drivers on the short stay unit and both were in good order and had stickers that demonstrated they had been safety checked and calibrated (a test to assure the accuracy of the equipment). Nursing staff explained the process to report a faulty syringe driver. Syringe drivers were stored and delivered or collected from the equipment library.

The service had suitable facilities to meet the needs of patients’ families. The hospital did not provide a designated ward area for those patients requiring end of life care. Care was delivered on all hospital’s wards. Patients were, however, moved to a single room when possible and some relatives told us they were provided with a temporary bed to stay overnight if they wished. Some wards had spaces and places where families could meet, confer and talk with care staff.
The viewing area in the mortuary, a dedicated room for bereaved family and friends, the bereavement office, the chapel and separate spiritual space for people of faith and no faith, met the needs of patients' families.

The service mostly had enough suitable equipment to help them to safely care for patients. Each ward had enough moving and handling equipment to allow patients to be cared for safely. Staff had access to all other equipment for patients at the end of their lives, including pressure relieving mattresses and air cushions. These were available through the equipment library. Staff told us they could access any equipment both in and out of hours.

Syringe driver equipment was recorded as a medium risk on the departmental risk register as they were not always returned to the hospital when a patient had been discharged and was no longer required, or they were lost in the hospital. The risk was entered on the register in January 2019 and was due for review in September 2019, to ensure equipment was available to provide safe patient care. We could not identify from the risk register what actions had been taken to reduce the risks. Staff we spoke with however, did not tell us of any incidents when a syringe driver had not been available when required and there were no incidents reported on the electronic incident reporting system from June 2018 to May 2019. As a potential lack of equipment had been recorded as a risk on the departmental risk register, we were not assured that reports of a delay in locating a syringe driver were reported as incidents in the correct way. This meant there was a risk that themes could be missed and that the review of the risk register may not be informed by the correct information.

At our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, the concealment trolley used for transporting bodies to the mortuary was in a poor condition and was due for replacement. During this inspection, we found a new trolley had been obtained.

The mortuary had four spaces for obese patients. There were specific storage trolleys and large fridges to accommodate them.

Staff disposed of clinical waste safely. Staff had access to clinical waste bags and clinical waste bins. Staff wore appropriate personal protective clothing when dealing with infectious or offensive waste. They washed their hands after handling even if they wore gloves. They followed correct procedure in case of a spillage.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In November 2018, the trust moved the governance of end of life care into the cancer directorate in line with the specialist palliative care team (SPCT). The move intended to provide co-ordinated leadership of the care of all seriously ill patients to ensure that patients received care more suitable to their needs. 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. Consultants had a discussion with each patient about what they wanted and the plan for escalation and we saw documentation confirming this in five of the care records we reviewed. The trust had developed a treatment escalation plan (TEP) that was being piloted on three wards at the time of our inspection. TEPs intended to ensure that every patient had their ceiling of care considered and documented to enable staff members to be aware of the limits of treatment in the event of a patient deteriorating. Medical and nursing staff told us the use of TEP forms were beneficial to the provision of safe patient care. The forms were readily accessible in the front of a patient file and contained information regarding do not attempt cardiopulmonary resuscitation.

The trust used several initiatives to identify deteriorating patients and ensure patients received care suitable to their needs. The initiatives included the introduction of the National Early Warning Score (NEWS2). The tool was developed by the Royal College of Physicians to improve the detection and response to clinical deterioration in adult patients. It is a key element of patient safety and improved patient outcomes.

The trust used an individual plan of care for the dying patient (ICP) that provided a structured approach to prompt staff to conduct regular checks on patients at end of life 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 commence mouth care was monitored by staff during these checks. Patient records demonstrated ward staff were completing a minimum of four-hourly review of symptoms and comfort measures for patients who had an ICP in place.

Staff knew about and dealt with any specific risk issues. Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing, and medical emergencies. This helped ensure patients were kept safe. Staff were aware patients receiving end of life care were most susceptible to pressure ulcers and automatically ensured they were cared for on correctly calibrated pressure-relieving mattresses. Deterioration in a patient’s condition was recorded and treatment amended as required. Patient records and observations of the delivery of care confirmed referrals for specialist services, such as to dietitians, were made when required.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff knew how to make an urgent referral to the psychiatric liaison service and told us they received a timely response.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The ICP included an assessment of a patient’s psychological needs. Staff told us they would refer patients to a cancer and palliative care clinical care psychologist when required. The psychologist was based at the hospital and provided support to patients who had experienced psychological distress as a result of cancer or other end of life illnesses. Staff knew how to make an urgent referral to the local county council mental health team if patients presented an immediate risk.

Staff shared key information to keep patients safe when handing over their care to others. Staff used structured communication tools that made it easy for them to remember to share important information. They used SBAR as a tool (Situation, Background, Assessment, Recommendation). Nurse ward huddles were held three times a day when risks were shared.
which highlighted, for example, if a patient had a do not attempt cardio-pulmonary resuscitation plan.

Shift changes and handovers included all necessary key information to keep patients safe. Staff handover meetings kept staff informed of the progress of patients who were at the end of their life. For example, patients were identified, and staff were informed of key information to keep them safe. Examples of such information sharing included whether the patient had been started on the end of life care pathway, had been referred to the SPCT, or could be moved only in exceptional clinical circumstances, or whether there was any family situation the staff needed to know about.

**Nurse staffing**

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.** Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. During 2018/9, there was significant staff turnover in the specialist palliative care team (SPCT) and vacancies included the lead nurse, a clinical practice educator, a palliative care social worker, palliative care consultant, and two administrative positions. The depletion in staff numbers across the specialties impacted on the provision of end of life care across the hospital, and the delivery of end of life care training to clinical and support staff was not consistent. There was a nominated lead or champion/link worker for end of life care on each ward. Champions/link workers had received one of three planned end of life training days since April 2019, to refresh or learn new skills to support them with undertaking the role. The second of the three-day training was planned, and the roles concerned the cascading of most recent guidance and best practice to general ward staff to support the delivery of end of life care. This is referred to in the competent staff section of this report. An end of life care lecturer nurse practitioner was also employed within the SPCT and supported the trust-wide delivery of end of life education.

A deputy head of nursing (DHoN) had commenced in post three weeks prior to our inspection and was the lead for acute cancer services and end of life care, and responsible for education and training within the division. There were six clinical nurse specialists (4.8 whole time equivalent) in the SPCT who reported to the DHoN. During the nine-month period when there had been no nurse lead in the service, some CNSs reported they had managed referrals to the team. At the time of our inspection however, there were safe staffing levels and no identified risk to the provision of safe patient care.

Managers accurately calculated and reviewed the number and grade of nurses and clinical support workers (CSWs) needed for each shift in accordance with national guidance. Staffing levels, skill mix and caseloads were planned and reviewed so patients received safe care and treatment, in line with relevant national guidance. The current planned establishment was identified as appropriate to deliver the service.

The managers could adjust staffing levels daily according to the needs of patients. Ward staff we spoke with told us there were daily meetings to support the organisation balancing staffing risk across the hospital. Each ward was rated as red, amber or green for each shift and provided a
monitoring process and assurance on nurse staffing levels. Where patient acuity or staffing levels demanded it, staff were moved to mitigate risks, or bank/agency staff were used to maintain safety. For example, consideration was given to the particular needs of patients at the end of life and staffing levels were adjusted accordingly.

The number of nurses and CSWs on all shifts on each ward matched the planned numbers. Ward managers completed the staffing acuity tool daily, which demonstrated planned versus actual staffing levels. We observed staffing levels on the wards we visited met planned numbers to ensure safe patient care. There were sufficient numbers of SPCT staff delivering the service and meeting patient needs, which included CNSs.

**Total staffing: planned vs. actual**

**Trust level**

The table below shows a summary of the nursing staffing metrics in services for end of life care at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All staff</strong></td>
<td>57</td>
<td>25%</td>
<td>45%</td>
<td>8.0%</td>
<td>458</td>
<td>171</td>
<td>685</td>
</tr>
<tr>
<td><strong>Qualified Nurses</strong></td>
<td>24</td>
<td>30%</td>
<td>70%</td>
<td>7.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service the trust had been analysed for the previous 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover.

The SPCT at Lister hospital had experienced a high turnover of qualified nurses during 2018 which contributed to the overall, trust-wide 70% turnover figure from April 2018 to March 2019.
Vacancy rates

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives were not stable. Vacancy rates increased from June to December 2018 when 16 out of 24 whole time equivalent qualified nurse positions arose. As vacancies were filled, the trust wide service had reducing vacancy rates.

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

Sickness rates

Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019.

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

Sickness rates decreased from 16% to 1% in January 2019 for qualified nurses and increased to near the trust average in March 2019.
Bank and agency staff usage

Bank hours - qualified nurses, health visitors and midwives

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. No bank qualified nurses were employed in the service across the trust which represented significant improvement from July 2018, when 160 hours of bank staff hours were used.

Agency hours - qualified nurses, health visitors and midwives

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. No agency qualified nurses were employed in the service across the trust from August 2018 which represented significant improvement from June 2018, when over 70 hours of agency staff were used.

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

Lister Hospital

The table below shows a summary of the nursing staffing metrics in services for end of life care at Lister Hospital compared to the trust’s targets, where applicable:
Nurse staffing rates within this core service at Lister Hospital had been analysed for the previous 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness. There was not enough variation in the monthly rates for vacancy, turnover, bank use or agency use to comment on performance.

Five of the 11 whole time equivalent positions in the SPCT became vacant from April 2018 to March 2019. At the time of our inspection, significant improvement was observed following recruitment to positions.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave all staff including locums a full induction.

**Trust level**

The table below shows a summary of the medical staffing metrics in services for end of life care at trust level compared to the trust’s targets, where applicable:
Lister Hospital

The table below shows a summary of the medical staffing metrics in services for end of life care at Lister Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>19</td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>1</td>
<td>-21%</td>
<td>55%</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>1</td>
<td>-21%</td>
<td>55%</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The medical staff matched the planned number on all shifts in each department. The medical staff matched the planned number, one whole time equivalent position, in the SPCT. The medical staffing model met the minimum requirements of the National Institute of Excellence (NICE) Supportive and Palliative Guidance 2004.

The service had low vacancy rates for medical staff. From April 2018 to March 2019 the trust reported an annual vacancy rate of -21% which meant vacancies had been filled above the planned whole-time equivalent hours. However, from August 2018 vacancies had been filled by locum positions and substantive positions recruitment was underway.

The service had reducing turnover rates for medical staff. From April 2018 to March 2019 the trust reported an annual turnover rate of 55% for medical staff in end of life care. This was in relation to one whole time equivalent position.

The service had low sickness rates for medical staff. From April 2018 to March 2019 the trust reported an annual sickness rate of 0% for medical staff in end of life care.

The service had increasing rates of bank and locum staff for medical staff. From April 2018 to March 2019 the trust reported zero shifts in end of life care that were covered by medical bank
or locum staff or left unfilled. However, this data did not reflect information provided by the trust during our inspection when two palliative consultant locums (one whole time equivalent post) had been recruited to the service in November 2018. The lead palliative consultant role was a joint appointment with a local hospice. The recruitment of substantive palliative consultants was entered as a moderate risk on the departmental risk register. Mitigation included ongoing recruitment campaigns however, due to a national shortage of palliative consultants a review of alternative roles, such as lead palliative care nurses, continued.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum)

Managers could access locums when they needed additional medical staff. The SPCT employed locums when vacancies remained unfilled and extended the contracts to ensure there were enough medical staff to keep patients safe from avoidable harm.

Managers made sure locums had a full induction to the service before they started work. Locums received a full induction to the service before starting a shift and a local induction checklist was completed and signed before each assignment.

Staffing skill mix
The service had a good skill mix of medical staff on each shift and reviewed this regularly. The palliative consultants were specialists and provided advice and support to medical staff across the hospital.

The service always had a consultant on call during evenings and weekends. Out of hours, clinical staff could receive specialist palliative care advice from an advice line run by the local hospice. Doctors we spoke with on the wards were aware of the advice line. We were told the service was responsive when requesting guidance and advice.

Records
Not all computer systems were accessible by staff which meant there was an increased risk some patient information could not be viewed when required, for example in the emergency department. However, staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and most were easily available to all staff providing care.

Patient notes were comprehensive and most staff, but not all, could access them easily. The care records and individual care plans of the dying patient (ICPs) we looked at followed the trust policy. In the medical notes of patients approaching the end of their lives, there were clear and detailed descriptions of their conditions and of the reasons behind the decisions to stop active treatment. Records contained evidence of consultant-led ward rounds, input from the multidisciplinary team, care plans and risk assessments. We reviewed four ICPs and the quality of information in the notes relating to end of life care, symptom management, discussions with families and patients where appropriate was of an acceptable standard.

At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, 22% of do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed did not include a summary of why CPR (cardio-pulmonary resuscitation) was not in the patient’s best interests. Since this inspection, the trust had changed
the forms in line with national guidelines, and they included sections which prompted details of communication with and the mental capacity of the patient. We reviewed 15 DNACPR forms and all were signed, dated and legible and all forms were completed as required by legislation. Since the October 2015 inspection, the resuscitation team lead regularly audited DNACPR forms in the hospital with the aim of driving improvement with completion of the forms. We observed audits of DNACPR forms were completed across inpatient wards from January to December 2018. Any alterations to the forms were raised with the ward manager at the time of the audit and ward staff confirmed learning was shared in daily huddles and team meetings. Action plans included allocating a member of ward staff with the role of checking new DNACPR forms each day. The audit results were not consistently shared across the service which meant ward managers were not aware of their ward performance.

The community DNACPR paper (mobile) forms were in a different format to the trust DNACPR forms, and there was a risk they may not always be up-to-date or transported with a patient to hospital. The medical director told us developmental work was ongoing with key strategic partners to review patient records across regional end of life care services, to support improved and safe patient care.

The trust had introduced an electronic palliative care coordination system (EPaCCS) which aimed to provide up-to-date key information about patients believed to be in the last year of their life. It was intended that communication and coordination would be improved across community and inpatient services to ensure all those involved in a patient’s care were aware of their wishes, preferences and advance care plan. During our inspection, hospital staff could not access EPaCCS as they had not received necessary training. Staff continued to depend on separate hospital and community paper records to review patients’ wishes, preferences and advance care plan. This meant there was a risk some information was not immediately accessible which may have increased unnecessary hospital admissions, the repeating of difficult conversations, and inappropriate interventions.

An end of life care alert was added to patients’ electronic records on assessment at the emergency department or on an inpatient ward. End of life care patient lists exported from the system were dependent on the entry being correctly made, which was not always the case. The butterfly co-ordinator, responsible for managing and providing the support of a volunteer to sit with a patient towards end of life, confirmed they visited wards each day and identified patients directly with ward managers. Information was subsequently shared with the SPCT, multi-disciplinary team co-ordinator who manually updated electronic records to reflect correct patient numbers.

There were many spreadsheets/forms to capture performance data stored within electronic records. Staff told us an end of life care dashboard was under development to support the sharing of information across the service and wider network. It was planned this would be available by the end of September 2019.

The service maintained the records within the mortuary. We saw staff completed mortuary records following trust protocol, which provided an audit trail.

When patients transferred to a new team, there were no delays in staff accessing their records.

There was a system for GPs to be informed if a patient who they provided care to had been identified as requiring end of life care, as this information was included in the care summaries sent to them on discharge. The care summaries included any medication changes. A similar
communication was sent with the patient to the care home if appropriate. Medicine changes, those of older people with complex needs, were communicated promptly to the GP. The electronic discharge summary included a prompt that enabled GPs to have information about their patient e-mailed straight to them to assist with rapid discharges.

Records were stored securely. Medical and nursing ward notes were well managed for patients at the end of their life. Records were organised and stored safely in key-coded locked cabinets to ensure the privacy and confidentiality of patients’ information. Mortuary records were stored in lockable cabinets.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Patients receiving end of life care were prescribed anticipatory medicines to enable prompt symptom relief at whatever time the patient developed distressing symptoms. Syringe drivers for the administration of medication were readily available. Medication for symptoms experienced by patients receiving end of life care was available on the ward and was easily accessible. The specialist palliative care team provided support to the team around medicines, and two specialist palliative care nurses were non-medical prescribers and one planned to complete the course in the near future.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicine.

The trust had guidance on anticipatory prescribing/just in case medicines at end of life. Staff prescribed anticipatory medicines to control key symptoms such as agitation, excessive respiratory secretions, nausea, vomiting and breathlessness, which may have occurred as an individual reached the end of their life. Patients (where patients were conscious) and carers were given advice about the medicine.

Staff stored and managed all medicines and prescribing documents in line with the trust’s policy.

All medicines stored on the wards were in a locked cupboard, medicine trolley or medicine refrigerator. The medicine cupboards complied with the trust policy and were kept locked. Medicines refrigerators were kept in a locked area and used only to store medicine. Staff recorded the temperature at least once each day and took standardised actions when it was not within a safe range.

Staff followed current national practice to check patients had the correct medicines.

There were clear guidelines for medical staff to follow when writing up antimicrobial and anticipatory medicines for patients including those medicines included within a syringe driver. Medicines were readily available to patients requiring treatment for palliative and end of life care. There was a county-wide approach to antimicrobial and anticipatory prescribing. The palliative care consultants jointly employed by the trust and the hospice had developed guidelines for palliative care prescribing.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
Safety alerts were posted on the staff bulletin board and staff were expected to have read and signed them. Medicine incidents which took place on other wards were shared across the organisation.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Palliative care consultants reviewed patients’ treatment in corroboration with other professionals within multi-disciplinary meetings to ensure excessive medication was not used to control a patient’s behaviour. In the records we reviewed we saw no patients who were having their behaviour controlled by medicines. Medical staff were competent at prescribing anticipatory medicines for pain, nausea, agitation, and secretions in line with National Institute for Health and Care (NICE) guidance and the “Five Priorities of Care”. For complex symptom management, medical staff could seek advice from the SPCT or out of hour’s service, and medical staff told us they used this service when required.

Incidents

The service did not manage patient safety incidents well. Staff did not always report them appropriately and lessons learned were not consistently shared with the whole team and the wider service. However, staff recognised incidents and near misses. Managers investigated incidents and, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. However, staff did not always report incidents they should report. 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 however, not all types of incident were reported appropriately. For example, one nurse told us they had raised two cases with the SPCT lead when they considered the patients should have met the criteria for support. They did not however, report the concern as an incident on the electronic reporting system. Furthermore, the availability of syringe drivers was recorded as a risk on the divisional risk register however, we reviewed incidents reported from June 2018 to May 2019 and identified no reports of difficulties with obtaining the equipment had been entered on the electronic risk register. This meant there was a potential risk that themes would not be identified and that opportunities for learning would be missed.

At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, the electronic incident recording system (the system to collect and report incidents) did not always identify the end of life/palliative care incidents. Some of the risks may be associated with medicine or cancer may be partly relevant to end of life care. There was a risk that the SPCT may not always have been aware of incidents relevant to them due to the way incidents were categorised. This meant opportunities to identify themes in end of life care incidents could be missed. During this inspection, we found an alert had been added to the incident reporting system to state if the patient was in the last 12 months of their life. This enabled managers to have an overview of incidents specific to end of life/palliative care such as syringe drivers, communication, record keeping, and recognition of the dying concerns. There were 106 incidents reported from January to July 2019 concerning patients in the last 12 months of their lives. The service recognised this was a low number and, in the April 2019 end of life care
steering group minutes, a senior manager reported they would like all incidents to be reported appropriately. Of the 106 incidents, most related to pressure ulcers and, in response, the medical service was reviewing the pressure ulcer policy.

**Never Events**

The service had no reported never events on any wards. From April 2018 and March 2019, the trust had reported no incidents which were classified as a never event for end of life care. Never events are serious patient safety incidents which 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 June 2018 to May 2019, the trust reported no incidents that were classified as a never event for end of life care.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff about never events that happened elsewhere.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with the trust policy. The trust followed the NHS England guidance on Serious Incident Framework Supporting learning to prevent recurrence (March 2015). Serious incidents were reported to the commissioners and recorded the incident on the NHS serious incident management system. The trust informed other regulatory, statutory, advisory and professional bodies about the incident depending on the nature and circumstances of the incident.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from June 2018 to May 2019. Both incidents occurred in the mortuary at Lister Hospital.

One incident was classified as a maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) and the other was classified as an incident affecting patient’s body after death meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

The trust used root cause analysis to investigate all serious incidents. Root cause analysis is used to identify the reasons that resulted in the serious incident and helps prevent the serious incident from happening again. For example, we observed an SI that occurred in the mortuary was fully investigated and learning was shared, and service improvements made to ensure safer care. A new consent form had been introduced to ensure patients were aware of the exact process they were consenting to as a result of the serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw evidence that duty of candour had been applied under the Health and Social Care Act (Regulated Activities Regulations) 2014 following three relevant 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 them with reasonable support. All staff were aware they would need to inform the patient or their relatives of the incident, make an apology and they explained how the hospital should respond to any incidents. Following an SI in the mortuary, all families were written and apologised to.

Staff did not consistently receive feedback from investigations of incidents, both internal and external to the service. Mortality and morbidity reviews took place as part of the cancer division meetings every week. Mortality and morbidity meetings are peer reviews of deaths and the care and treatment patients had received, with the objective to learn from them. Consultants identified those patients to review and identify areas of learning. A mortality surveillance committee scrutinised mortality reports and we observed actions included the sharing of outcomes across divisions to promote learning. For example, the October 2018 minutes agreed one mortality and morbidity review outcome should be flagged with the end of life care steering group for learning. However, there was no specific agenda item in the April, June, and July 2019 steering group minutes to capture feedback from incidents. Furthermore, in the April 2019 minutes it was discussed that there was no consistent route for disseminating learning from the mortality and morbidity reviews and that, at that time, ‘more informal chats’ were being held. An action plan included the mortality improvement lead capturing the learning in a spreadsheet that was planned to be discussed and shared within steering group meetings. The lead was not in attendance at the June and July 2019 meetings and there was no evidence of further discussion or agenda item to support the item being carried forward.

Staff met to discuss the feedback and look at improvements to patient care, however this was not always consistent. SPCT clinical nurse specialists (CNSs) attended a monthly CNS forum where learning was shared from incidents. Ward staff attended twice daily huddles where learning from incidents and practice improvement was discussed.

The end of life care steering group discussed incidents and the learning points however, the agenda and minuting of actions was not clear. For example, the steering group reviewed the future meeting agenda in April 2019 and, whilst complaints were a standard agenda item, incidents were not. There was an agenda item regarding a patient story and, in the June and July 2019 minutes, we observed learning from case examples was discussed. However, there was no incident agenda item in the June 2019 minutes and, in the July 2019 minutes, there was an agenda item for complaints/incident reporting system however, no specific incidents were discussed. Furthermore, there was no incident agenda item in the March and April 2019 SPCT team meeting minutes. We were not assured the service was consistently discussing incidents or capturing required service improvements/learning to support the effective cascading of learning throughout the service.

There was evidence that changes had been made as a result of feedback. For example, staff were aware of SI outcomes arising in other directorates relating to inappropriate CPR (cardio pulmonary resuscitation) attempts. Treatment escalation plans were being piloted on three wards to drive up service improvement.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust used root cause analysis to investigate all serious incidents. Root cause analysis is used identify the reasons that resulted in the serious incident and helps prevent the serious incident from happening again. We learned that one complaint that occurred at another
site within the service was investigated using root cause analysis and the family was kept informed of the investigation.

Managers debriefed and supported staff after any serious incident. Staff told us there was considerable support from managers after any serious incident. Staff involved in the investigation process had the opportunity to access professional advice from their relevant professional body or staff counselling service. Managers provided staff with information about the stages of the investigation and how they would be expected to contribute to the process.

Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and best practice. Managers did not always check to make sure staff followed guidance. Not all internal audits were completed in accordance with the trust’s agreed timetable. However, staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high-quality care according to best practice and national guidance however, not all audits were completed when required and not all policies were up to date. The documentation used for end of life care met recommendations in line with the National Leadership Alliance for the Care of Dying People: One chance to get it right (2014) and the National Institute for Health and Care Excellence (NICE): Care of dying adults in the last days of life (2015). This guidance included five priorities to ensure high quality and consistent care for patients in their last few days and hours of life. There was a programme of internal audits of end of life care however, not all audits had been completed during 2018, and some were overdue. Planned audits included individual care plans (ICPs), time from referral to assessment, do not attempt cardio pulmonary resuscitation (DNACPR) forms, and the number of patients who achieved their preferred place of death (PPD). The last audit of the number of patients who achieved their PPD was undertaken from January and March 2017. This was not in line with National Institute for Health and Care Excellence (NICE) guidance Care of dying adults in the last days of life NG31 2015. We asked the trust to provide results from the most recent audit of syringe pumps to check they were routinely locked to prevent tampering/accidental changes to these pumps and to assure it was in line with trust policy. They reported that no recent audit had been completed as the policy and training programme was being updated. Further syringe pump training was planned in September 2019 and the trust confirmed an audit would begin in October 2019.

Advance care planning is used to describe a process and the conversation between people, their families, carers and those looking after them about their future wishes and priorities for care. The main goal is to clarify patients’ wishes, needs and preferences, their spirituality, and deliver care to meet these needs. The trust told us they had not previously monitored or audited advance care planning in the hospital. However, they intended to work with the local clinical commissioning group within the end of life steering group to review the use of treatment escalation plans in conjunction with advance care plans. They planned to audit their completion and include outcomes within the end of life care dashboard. No date was confirmed for the work to be actioned.
The service monitored however, did not consistently report, local performance measures to the trust's end of life care steering group. The information was available in separate reports/formats and, whilst an end of life dashboard had been planned since the beginning of 2019, this was not available at the time of our inspection. Staff confirmed the dashboard would be available from September 2019 when performance data would be presented monthly in one spreadsheet. Ward staff were not aware of their individual end of life care ward performance which meant there were no local action plans to review service improvements. For example, many ward staff were not aware of the outcome of the most recent DNACPR form audit. Some staff within the SPCT and rapid discharge team did not know how many patients achieved their preferred place of death. We were therefore not assured that care was always delivered in line with best practice.

The trust was meeting guidance for end of life care from the National Institute for Health and Care Excellent (NICE). For example, the specialist palliative care nurses provided advice and support to staff and patients about the prescribing of anticipatory medications in line with the ‘care of dying adults in the last few days of life’ NG31. Staff on the wards confirmed there was communication and shared decision making with the specialist palliative care nurses.

The bereavement service had processes to ensure all procedures after a patient’s death were completed in a timely manner to enable relatives to make funeral arrangements. There were systems for the completion of required documents and actions in line with NHS England guidance to ensure the needs of bereaved people were met. The bereavement service provided families and carers with leaflets about bereavement and the next steps following the death of their loved one.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff in end of life care knew the new (2015) Mental Health Act and the code of practice. For example, they knew the five new guiding principles, and its application to human rights and health inequalities.

Staff on the wards were piloting a treatment escalation plan (TEP). The TEP had information about treatment options to be discussed with the patient or their relative if they did not have the mental capacity to make their own valid decisions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The SPCT understood the importance of identifying people considered to be in their last 12 months of life. They demonstrated in-depth knowledge of how care, including mental health care, could be improved for these patients. Clinical nurse specialists and consultants from the SPCT attended staff huddles, MDT meetings, and ward rounds when required to ensure the complex needs of patients were shared with staff.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs. Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.
Nutrition and hydration were included in the daily assessment in the priorities of care nursing care plan. Medical staff knew the General Medical Council (GMC) guidelines for nutrition and hydration in end of life care. Nurses made referrals to the dietitian and assessed and supported the patients with their nutrition needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed five sets of patient notes and found staff had fully and accurately completed fluid and nutrition charts. There were examples of what patients had eaten at various times of the day. If a patient was prescribed liquid dietary supplements, these were recorded.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used Malnutrition Universal Screening Tool (MUST) when they assessed patients at risk of malnutrition. They monitored the daily assessment in the priorities of care nursing plan to identify patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff could made direct referrals to gain expert advice about swallowing. This was available to all patients when required.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff monitored patients' pain using an assessment tool in accordance with NICE Quality standards. Our inspection of ten medical and nursing records showed symptom control for patients at or near the end of life had been managed to the relevant NICE Quality standard. This standard defined best practice for the safe and effective prescribing of strong opioids for palliative care. Pain scoring was completed for patients every time their vital signs were recorded. For patients on the priorities of care individualised care plan (ICP) this was a minimum of three times a day and after any interventions, including medicines, were given.

Though a recognised pain assessment tool was not in use, nurses reviewed patients' pain and its control regularly. We did not observe any patients in pain during our inspection. Relatives told us staff regularly came to assess patient pain control. The specialist palliative care nurses discussed patient symptoms (including signs of pain) with staff, to ensure the prescribed medicines met the needs of patients to ensure their comfort.

Patients received pain relief soon after requesting it. The specialist palliative care team responded quickly in supporting staff to ensure there were no delays in responding to a patient's increase in pain as it happened. Patients told us they were asked about their pain at regular intervals and given pain relief where appropriate. All staff were pro-active in managing patient's pain. We reviewed five nursing records for patients in the last days of life and saw where pain assessments were included in the ICP. After giving patients pain relief, staff asked them whether the pain relief had worked.

Wards were well stocked to ensure prescribed pain medicines were available. Staff had access to syringe drivers to enable the continuous infusion of medicines when these were prescribed.
saw that anticipatory (‘just in case’) pain medicines were prescribed for patients in their last days or hours of life. Staff felt confident in their use.

Staff prescribed, administered and recorded all pain relief accurately. We inspected four prescription charts and found pain relief was recorded accurately. In all records, we found the right medicine was prescribed and administered accurately. Staff had access to an acute pain team for support in managing patients’ pain and the SPCT visited all patients with a syringe driver being used to provide pain relief.

**Patient outcomes**

The service monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for patients.

The service participated in the relevant national clinical audit. The service performed well in some areas of the national clinical outcome audit and managers were using the results to develop an action plan to improve services further.

There were nine key components identified in the latest 2019 *National Audit of Care at the End of Life (NACEL)*. The trust scored better when compared nationally in four out of nine indicators. These were as follows:

1. Individual plan of care
2. Families and others experience of care
3. Governance
4. Workforce/specialist palliative care

The trust scored worse when compared nationally in five out of nine indicators. These were as follows:

1. Communication with the dying patient
2. Communication with families and others
3. Involvement in decision making.
4. Recognising the possibility of imminent death (close to national indicator)
5. Needs of families and others (close to national indicator)

We saw that an action plan was being devised in each specialty to address deficits in the service and that the completion date was 22nd October 2019. All areas that were not compliant with the key indicators were allocated a risk score and, where required, this would be added to the risk register.

A bereavement survey was completed to ensure the service could support families through to bereavement, although there was a low response rate, which meant it was difficult to analyse trends. It was envisaged that a gap analysis may support service leads with identifying any areas of risk to meeting the needs of the bereaved, for example.

Managers did not carry out a comprehensive audit programme. Since end of life care had transferred to the cancer directorate in line with the SPCT, a revised audit programme was under development. Future planned audits included the following:

1. Syringe pump competency audit to ensure safe use
2. Rapid discharge/patients achieving their preferred place of death
3. Advance care plans
4. Treatment escalation plans

Audits currently completed and included in the future schedule included:

1. Participation in the second NACEL audit
2. Treatment escalation plan audit
3. The trust’s the key performance indicators
4. Mortality review to be undertaken quarterly

Do not attempt cardiopulmonary resuscitation process compliance audit to be undertaken quarterly.

Managers did not always use information from the audits to improve care and treatment. Some audit data was not current which meant the opportunity to develop service improvements had been missed. For example, the preferred and actual place of death audit was last completed from January to March 2017. This meant the service was unaware if practice could be changed to improve patient outcomes at the end of life. The SPCT had joined a national Outcome Assessment and Complexity Collaborative (OACC) developed in partnership between both local and national organisations. The initiative supported the routine use of assessment tools and outcome measures in palliative care practice. It aimed to enable clinical teams to make the most effective use of information collected, both when planning the care of individual patients and at an organisational level to systematically improve the quality of palliative care services and to minimise variations in practice. One of the three tools implemented by the service was an integrated palliative care outcome score and we observed clinical nurse specialists using the scores to measure and compare physical, psychological, social and spiritual issues to determine patient outcomes.

There were engagement meetings or follow-up of audit outliers however, they did not support the consistent monitoring of outcomes. The end of life care steering group agenda was reviewed in April 2019, with the aim of driving up performance in achieving best patient outcomes. Actions from the April 2019 meeting included a review of end of life care performance measures, for example, the end of life care training programme. However, there was no specific agenda item to follow up audit outliers, and no evidence of discussions in the June and July 2019 end of life care steering group minutes. This did not enable audit outliers to be consistently monitored to ensure performance was improved, or new actions to be devised.

Managers did not always share and make sure staff understood information from the audits. The results of audits were not consistently shared at the monthly end of life care steering group meeting or cascaded to ward staff. This meant staff were not aware of their own ward end of life care performance. Manager did not always have formal written plans to drive up performance. An end of life dashboard was under development however, to provide information from board to ward level. Staff were aware of action plans to drive up compliance with completion of DNACPR forms, which included the checking of all new patient forms each day. However, they were not aware of their ward’s overall performance.

Improvement was checked and monitored in some areas. An end of life care survey was completed from April 2018 to March 2019 to measure and improve patient outcomes. Whilst there were a low number of responses, from one to five on each ward/unit (50 overall), all comments were forwarded to the appropriate ward manager and matron. Patient comments were monitored
to identify any trends and teaching/support was provided from the palliative care team, where required, to improve patients’ experience of care. Positive and negative feedback was shared with the director of nursing and discussed at the end of life care steering group.

The resuscitation officer monitored the completion of do not attempt cardiopulmonary resuscitation forms and checked on individual wards that there was consistent improvement with the quality of information.

**Competent staff**

The service did not make sure all staff were competent for their roles. However, managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Not all staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. An end of life care awareness session, which covered the identification of people in the last 12 months of their life in the last year, was provided to all staff within the trust induction. Further one-hour sessions on the priorities for care of the dying person were also delivered to new clinical support workers, and new band 5 nurses. Ward staff received end of life care up-skilling from staff within the SPCT and from ward champions who had received specific additional training. However, vacancies in the SPCT during 2018/9 including a clinical practice educator, meant not all ward staff or champions had received training to an appropriate level for their role. End of life care champions told us they found the training useful however, champions had received only one of three planned training sessions at the time of our inspection. Since April 2019, there had been a renewed focus on upskilling staff across the hospital to ensure end of life care was ‘everybody’s business’. Ward based, week-long training workshops were delivered by staff in the SPCT which meant attendance/compliance had improved. For example, all nursing/clinical support workers on ward 10 had received end of life care training. However, training had been delivered to wards on three out of five floors at the time of our inspection, and we were not assured all end of life champions and ward staff had the right skills and knowledge to support the effective delivery of end of life care. The delivery of training to staff was not entered as a risk on the divisional risk register and the April, June and July 2019 end of life care steering group minutes confirmed more staff training was required.

A palliative consultant had delivered some palliative/end of life care training sessions to junior doctors during 2019 and planned to develop a consistent, rolling programme of training from September 2019. They aimed to identify a medical champion in each speciality, and a renal physician had already been identified. However, champions were required in all specialities to disseminate information and raise awareness of the delivery of end of life/palliative care.

The trust had a structured syringe driver training programme to ensure all relevant staff received the same standard training from the same trainer. The training programme was based on competencies identified. On completion, staff needed to carry out a competency assessment on their ward, under supervision. Only once the supervisor signed these off, were staff allowed to use the syringe driver. At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, ward managers did not have access to SPCT training information and did not know which of their team had attended syringe driver training. During this inspection, one manager did not know where to find the syringe driver training records which meant there was a risk that they did not have an oversight of where the skills and the training needs were in their team. The ward manager would have been unable to consider the
training information when organising the rota. In the July 2019 end of life care steering group minutes, it was reported by the chair that it was ‘…difficult to keep up with training’ and there was an action for all band 7s, 8s, deputy directors of nursing, and the head of nursing to undertake syringe driver training within four weeks. We asked the trust to provide the numbers of staff who were competent in the use of syringe drivers and they confirmed that 90% of eligible staff on wards 11b, 8a, and 5a would be trained/competent by the end of August 2019. Data confirmed nurses on ward 5b and 8a were recruited from overseas and were required to complete an objective structured clinical examination (OSCE) before advanced training/competencies could be completed. The trust confirmed that there would be competent nurses on ward 8b and 5b that would support any end of life care patient who had a syringe driver present; however, they did not provide the numbers of eligible and compliant nurses. In mitigation, the duty matron and clinical site team were competent in the use of syringe drivers and available to support staff. We were not assured however, there was robust system to capture the ongoing review of staff training and competencies for eligible staff. The trust told us further training was scheduled for September 2019.

Mortuary staff provided training to porters on how to transfer the deceased patient. The resuscitation team provided the basic life support and immediate life support training on site. The chaplaincy team had attended study days within the hospital and externally to enable them to update/maintain their practice. Staff from the bereavement office provided training for junior doctors on completion of death certificate of cause of death.

Managers gave all new staff a full induction tailored to their role before they started work. There were competency packages for all clinical and non-clinical staff to be completed. A ward induction checklist was completed and signed by a ward manager and staff member before a temporary staff member started their first shift.

Managers did not support all staff to develop through yearly, constructive appraisals of their work. However, compliance was near the trust target and those outstanding were scheduled at the time of our inspection.

**Appraisal rates**
From April 2018 to March 2019, 83.3% of staff within end of life care service at the trust received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>7</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>10</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
</tr>
</tbody>
</table>
Lister Hospital

From April 2018 to March 2019, 71.4% of staff within end of life care at Lister Hospital had undergone an appraisal compared to a trust target of 90%. However, there were low numbers of staff in some staff groups in end of life care at Lister Hospital. This meant that rates could be misinterpreted.

Two clinical nurse specialists told us their appraisal had been booked with the newly appointed service lead.

All mortuary staff had undergone an appraisal.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>14</strong></td>
<td><strong>71.4%</strong></td>
</tr>
</tbody>
</table>

The palliative consultants were employed as locums and therefore were not eligible to receive an appraisal.

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

Managers supported staff to develop through regular, constructive clinical supervision of their work. Clinical nurse specialists (CNSs) received regular clinical supervision of their work.

There were enough clinical educators to support staff learning and development. The SPCT employed a nurse lecturer practitioner, clinical practice educator, and education administration support. The clinical practice educator position had been vacant during 2018/9 which meant there had not been enough educators to support staff learning and development. A newly recruited practice educator started in the role during the week of our inspection which meant there would be enough educators, following induction, to support staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We asked for copies of the last two SPCT staff team meeting minutes and were provided with March and April 2019 minutes. We were not assured that team meetings had occurred in May, June and July 2019 which meant there may have been missed opportunities for the sharing of learning or service developments. CNSs attended a CNS forum on a rotational basis, which supported their development.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All members of the SPCT had received specialist training for
example, in advance symptom management.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff said they were encouraged and supported to complete some new training programmes to develop their skills and knowledge. This was done through appraisals.

Managers made sure staff received any specialist training for their role. All members of the specialist palliative care team had received specialist training for example, in advance symptom management. Some staff, including a ward sister, had completed a ten-day palliative care course during 2018.

Managers identified poor staff performance promptly and supported staff to improve. Managers highlighted how staff who did not perform to an expected standard, were made fully aware of where their performance did not meet the required standard and support and encouragement was given in an effort to effect improvements. Staff said how there were open and honest two-way conversations between themselves and their manager. Staff were encouraged to speak up about issues that affected their performance at work.

Managers supported with the recruitment and training of volunteers to support patients in the service. For example, some Butterfly volunteers had attended workshops or training, such as sage and thyme communication skills training. (Sage and thyme is a training model providing person-centred, evidence-based communication skills to people with emotional concerns).

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff attended weekly multidisciplinary meetings to discuss patients and improve their care. The specialist palliative care team (SPCT) attended several other specialities MDT meetings, for example, respiratory, upper GI and the renal specialty meetings. The aim of the meetings was to review patients and provide support and advice about the management of patients nearing the end of their life and who had complex needs.

Whilst the SPCT did not hold their own team MDT, complex case reviews were held between a palliative consultant and clinical nurse specialists to promote the sharing of best practice. However, there was no pharmacy, approved health practitioner, or clinical psychology input to support effective collaborative decision making.

Membership of the end of life care steering group meetings well attended. For example, the resuscitation lead, head of nursing, hospice representative, bereavement officer, chaplain, education lecturer practitioner, and medical director attended the June 2019 meeting. Staff worked across healthcare disciplines and with other agencies when required to care for patients. For example, with Macmillan staff, social care staff, GPs, community teams.

The butterfly co-ordinator (who trained volunteers to support dying patients, their families and family at end of life) visited the wards each morning to see if any patients had been admitted who
were known to them, or who may require a referral to the service. The co-ordinator shared information with the SPCT staff to support effective MDT working.

There were established links with mental health services, learning disability and dementia services. There were good working relationships with all departments such as the emergency department, other specialist nurses and the medical services caring for older people. The service continued to work hard to improve communications with other staff and services involved in patient care.

The discharge coordinator supported fast track discharge of end of life patients to their preferred place of death.

There was good multidisciplinary working between the chaplaincy and the SPCT. There were processes for regular meetings throughout the working week. This helped patients receive the emotional support required as well as serving to provide emotional support to colleagues.

There was close working with the local hospice with regular meetings to discuss patients who were in the hospital and known to the hospice service. These meetings enabled continuity of care where advice and support from the specialists at the hospice could be obtained for the care and treatment of patients. These meetings were attended by the specialist palliative consultant and nurses, and representatives from the local hospice and community nursing teams.

The trust had introduced an ‘electronic palliative care coordination system (EPaCCS). Another healthcare provider hosted this register. The purpose of this register was the recording and sharing of patients’ care preferences and key details about their care at the end of life across providers. Patients needed to consent to the sharing of their information before they were added to this register. Staff at this trust were not able to log onto the EPaCCS system to update a patient’s preferences or to add a new patient. Staff training was required to ensure the effective sharing of patient information.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Consultants did twice daily ward rounds during the week. At weekends, consultant-led ward rounds took place once a day. A palliative care consultant reviewed complex cases when required.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The dedicated SPCT provided support throughout the hospital seven days a week from 9am to 5pm. Out of hours telephone support (during evenings or overnight) was provided by a local hospice. The chaplaincy team provided cover 24 hours a day, seven days a week. The mortuary service was open from 8am to 4pm, Monday to Friday and an on-call service was provided outside of these hours. Death certificates could be obtained out of hours on the grounds of religious or cultural needs. The bereavement office was open from 8am to 4pm, Monday to Friday. There was no facility for bereaved families to view their deceased relative in the mortuary out of hours; the relatives were required to wait until the next working day. However, a viewing service was provided on bank holidays on request. Urgent mental health referrals could be made to a crisis assessment and treatment team and staff
knew how to access this. Porters provided a seven day, 24-hour service to transfer the deceased from the wards to the mortuary.

**Health promotion**

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Patients were offered information on how to help themselves with activities of daily living. For example, for bathing and showering, the use of specialised or adaptive equipment to maximise safety. To promote meal preparation, patients were guided how to reorganise their kitchen storage for easier access.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. To promote healthy lifestyles, patients were provided with what they wanted. This included relaxation techniques such as yoga or meditation and sometimes, just a general chat. The chaplains provided opportunities for such general chats that helped patients come to terms with the end of their life.

A renal support group was held each month for patients could approaching the end of life. Patients were provided with an opportunity to meet other patients and ask any questions from staff and volunteers running the group.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, there was no evidence that staff had completed mental capacity assessments (MCA) in the decision-making progress for any of the 27 patient records we reviewed. The trust’s do not attempt cardio pulmonary resuscitation (DNACPR) forms did not ask if the patient had capacity to make and communicate decisions about CPR. Without this, there was no immediate prompt for staff to assess patient’s capacity when making a decision about DNACPR. During this inspection, we found significant improvement in that the trust DNACPR form was changed in line with national guidelines and included communication and capacity sections of the patient. Staff knew the assessments of capacity should be time and decision specific. They highlighted that one should not decide if someone lacked capacity based upon age, appearance, condition or behaviour alone. In all 15 (100%) DNACPR forms reviewed, the capacity prompt had been completed and patient records detailed when an MCA had been completed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence including documentation in all 15 DNACPR forms where steps had been taken to involve a person in making decisions in advance of when they might lack capacity.
When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us when deciding what was in the best interest of the patient, they needed to consider how the past and present wishes and feelings, beliefs and values may have influenced the decision taken by the patient if they had capacity and other factors the patient would like them to consider if they had capacity.

Staff made sure patients consented to treatment based on all the information available. Staff were aware the person who gave consent must be given all the information about what the treatment involved. This included the benefits and the risks, whether there were reasonable alternative treatments and what will happen if treatment did not go ahead.

Staff clearly recorded consent in the patients’ records. At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, there was no information related to MCA assessments in patient records reviewed. Staff were effectively making decisions about patient’s capacity without recording consideration of capacity or returning to discuss a decision with the patient if they had been confused, for example. This meant staff who had obtained consent from patients did not comply with the Mental Capacity Act 2005. During this inspection, there was significant improvement and consent was clearly recorded and signed and related to MCA assessment outcomes.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 100.0% of eligible nursing staff in end of life care. It should be noted that the data for nursing staff refers to six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training was delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at trust level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>16</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>16</td>
</tr>
</tbody>
</table>

In end of life care the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in end of life care is shown below:
In end of life care the target was not met for either of the MCA/DOLS training modules for which medical staff were eligible. Again, there are low numbers of medical staff working in end of life care at the trust, this can affect the results.

Lister Hospital

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at Lister Hospital for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td></td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

Following our inspection, the trust provided data that confirmed medical staff (one whole time equivalent) had completed safeguarding training that included MCA/DoLS training.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff were knowledgeable about the process involved in applying for a Deprivation of Liberty Safeguards, although no patients were subject to one at the time of inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff described how they could access support and advice via the trust wide intranet.

Managers monitored how well the service followed the Mental Capacity Act and made changes to
practice when necessary. Regular audits of the completion of DNACPR forms were completed and ward staff were informed if a change in practice was required.

**Is the service caring?**

**Compassionate care**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff showed discretion when caring for patients. They demonstrated compassion when they interacted with patients at the end of their life and their families.

Communication between staff and their relatives and saw that staff were caring and respectful. Many staff in the specialist palliative care team (SPCT) had been trained in advanced communication skills. We observed a member of staff being discreet and responsive when caring for a patient on end of life care. The individual was called by their preferred name. The individual was comfortable the way the member of staff spoke with them. The interaction was at a pace which recognised the importance of helping create a relaxed atmosphere.

Staff told us they felt they were able to care for people with dignity and respect and had sufficient time to care for patients and their families. The care and treatment of patients requiring end of life care and palliative care within all departments that we observed, was flexible, empathetic and compassionate.

Staff members spent time with the patients and interacted with them during any tasks or clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. We observed one nurse spending time with a patient and their relative to discuss symptom management that was communicated in a sensitive and compassionate manner. The patient’s relative told us, “The staff are wonderful – all the nurses are kind and caring”. A bed was provided for the relative to stay overnight and they told us they had been provided with spiritual support when required.

All staff we interviewed spoke passionately about providing high quality, compassionate, individualised care. Staff developed trusting relationships with patients and their relatives. Staff encouraged family members to visit, including children. Family pets could visit by arrangement. Visitors were offered hot drinks and soft seating was available in some visiting areas.

Patients said staff treated them well and with kindness. We observed letters and cards of thanks from relatives on display on staff noticeboards. Thank you, cards, given to staff included comments, “You were extremely supportive to me in my most difficult moments. I will always be very grateful to you for that”; and “Thank you for your care and extreme kindness to my mum, myself and my family”. Relatives told us staff treated their loved ones with kindness. For example, one relative told us the doctors and nurses were “superb”, and a second relative commented that the respiratory consultant was “excellent”.

We reviewed patients’ files and saw medical and nursing notes were respectful and considerate of the patient and their families.
We were given examples of where staff went the extra mile to support patients and their families at the end of life. A wedding was held on one ward during 2018 and all staff worked together to make sure the wedding happened as soon as possible after the request was made. A further example concerned ward staff arranging for a patient’s dog to visit their owner in hospital.

Staff followed policy to keep patient care and treatment confidential. Staff did not share the patients’ names or the care they received to their work colleagues. They ensured rooms were always closed or the curtains pulled when they wanted to talk with the patient.

Staff at the trust had adopted the butterfly symbol as the dignity in death symbol. This alerted non-clinical staff to the fact that a patient was at the end of life or had died. This meant that staff knew to speak with clinical staff before entering a room.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us they would seek support from link nurses in matters relating to mental health, learning disabilities and dementia when required. All staff understood how discussions about advance care planning would provoke anxiety in patients without any mental impairment, so it was likely to be more difficult for patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff knew the various personal, cultural, social and religious needs of patients. Hospital porters transferred deceased patients to the mortuary in a discreet and respectful manner. The mortuary staff ensured that any religious or cultural wishes were respected. The chaplain worked with the families to ensure the relevant paperwork was completed in a timely manner to allow for the religious needs of patients to be met. Patients and visitors were able to access the multi-faith chapel at any time, and staff within the SPCT invited relatives and friends to a remembrance service once a year.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. When needed, staff took time to sit with the patient or their relatives and provided them with support. One family member told us how instrumental staff were to them as they gave strength and support to the dying person. They told us: “I just could not have done what I did without the emotional support and advice from staff. I know I still have them to reach out to, if needed.”

The bereavement team kept relatives updated of any delays with releasing the body; for example, where a post mortem was required. They offered practical advice and signposted relatives to other services as required.

The butterfly volunteer project provided one-to-one companionship for dying patients who had few, or no visitors. The team also supported families and carers, providing them with respite whilst they cared for their loved ones. One thank you card stated, “Our whole family would like to express how thankful we are”. The relative commented that knowing there was a butterfly volunteer to be by their relative’s side brought them comfort.
The renal liaison team provided emotional support for patients at end of life; a team of counsellors and social workers was available to provide psychosocial support when required.

The chaplaincy service was available to provide spiritual and pastoral care when asked by the patient/families and members of staff. The team offered support, prayers or a listening service to people who may find it helpful to talk about their anxieties. ‘Mindfulness’, mediation sessions were available to patients, relatives/carers and staff across the hospital on a weekly basis. The sessions aimed to reduce anxiety and stress.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Formal assessments were completed for patients with depression and delirium. Psychology services at the hospital maintained close links with professionals from services outside of the general medical field, such as mental health and the voluntary sector.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Some staff had received training on breaking bad news. They told us how they had to learn to build resilience as they broke bad news to patient or families. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were empathetic to the people’s care and understood how their wellbeing was affected. Consenting patients were referred to the trust’s psychology services when additional emotional support was required. The clinical and counselling psychologists provided assessment and support for patients in coping with physical health conditions, including life-limiting illnesses.

One clinical nurse specialist (CNS) in the SPCT had completed level two psychological support training in July 2017 that supported assessing and meeting patients’ emotional needs.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The nature of the care provided to patients in the end of life care service meant patients could not always be involved in decisions about their care. However, the views and preferences of patients were considered when possible. One patient told us the nursing and medical staff always involved them in honest discussions, and that they understood and were involved in their care plan. A relative told us that, whilst they were “very happy with the care”, the questions asked by the clinical nurse specialist about the patient’s condition were addressed to the family members when their relative “wanted to know what was being said”.

Patient records we reviewed contained detailed documentation about caring discussions held with patients and those close to them. We observed records included conversations about advanced care planning, and considered sensitive discussions around preferred place of care at end of life, prognosis and symptom management.

Relatives or friends were encouraged to be involved in care planning and support their loved ones. Those identified as wishing to take an active part in the care of their loved one were provided with
a carer’s passport. This detailed the area of agreed support the relative or friend would provide, such as with assisting at meal times. A carer’s passport entitled the relative or friend to free car parking and a reduction at the staff canteen to support them with continuing to be involved in the care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families sent in notes of appreciation and thank you cards to staff. A bereavement survey had been completed in end of life care services to identify how involved relatives felt in decisions about care and patients could participate in an experience of care questionnaire.

Staff supported patients to make advanced decisions about their care. Staff helped patients empower themselves to make advanced decisions about their care. Patients were identified as likely to be in the last 12 months of life within multi-disciplinary ward rounds. Early identification supported increased focus on symptom control and burden of illness and improved team awareness to support care planning. It also supported patients to explore wishes, worries and priorities in the short and longer term.

Staff supported patients to make informed decisions about their care. Patients were provided with an opportunity to create an advance care plan, including end of life care wishes, and consider organ donation. An individual plan of care for the dying patient (ICP) was developed in the last days of life and these contained prompts for staff to include patients and those close to them in discussions about their care.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The NHS Friends and Family test (FFT) is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. We saw May 2019 inpatient results which showed 96.4% of patients completing the survey would be extremely likely, or likely, to recommend the service to family and friends. This was slightly higher than the England average of 95%.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Since November 2018, two palliative care consultants were employed at the hospital and the lead position was a joint appointment with the community, working with a local hospice. This assisted with facilitating the planning and organisation of services within hospital, community, and hospice settings. An end of life care steering group was attended by local stakeholders to review end of life care practice across the region and ensure services were responsive and met the needs of the local people. However, there was no representative from the local clinical commissioning group in attendance in April, June or July 2019. Education provision was co-ordinated and shared between local services, and attendance at multi-disciplinary meetings supported the sharing of local people’s current and future changing needs. Furthermore, an integrated strategy was planned in corroboration with stakeholders to improve clinical pathways.
and transitions from one service to another. Leads in the service engaged with GPs to support local people with receiving a streamlined, end of life care service. Within the hospital, the service was under development and end of life care was a focus within all staff groups and specialties to ensure all areas of end of life care were targeted and that people’s needs were met.

The trust had employed an end of life care discharge coordinator who organised the discharge of patients from the hospital who were at the end of their life. This often needed to be done quickly if they were to get the patient to their chosen place to die. The hospice discharge coordinator spoke with other staff and could often arrange a rapid discharge within a day and sometimes a few hours. The hospice discharge coordinator involved other allied health professionals, such as occupational therapy services, who could organise specialist equipment to be set up at the patient’s home. The integrated discharge team were working with the SPCT to develop the rapid discharge home in the last hours of life guidance to ensure patients could achieve the preferred place of death.

There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. Reduced parking fees for relatives of patients receiving end of life care could be arranged, to allow relatives to spend the maximum amount of time with their relative.

The SPCT collaborated with other providers in the local area, including the local hospice, primary care providers and community nurses to plan services and meet the needs of local communities it served.

The SPCT lecturer practitioner contributed to the education strategy across the county. Courses/workshops were delivered by hospital and key stakeholder staff in a range of locations such as hospices, hospitals, and community venues to ensure the needs of local people were met. The courses ranged from introductory end of life care/communication workshops to advanced communication; and symptom control training. Some staff told us they had attended workshops or training, for example, butterfly volunteers completed sage and thyme communication skills training.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff always ensured patients who received end of life care were cared for in single sex accommodation. Staff knew what actions to take when there was a potential breach.

Facilities and premises were appropriate for the services being delivered. The hospital did not have any designated end of life or palliative care wards or beds; patients were nursed as required across all wards. Patients at risk of infection or those who were infectious were prioritised for side rooms to prevent cross infection with other patients. However, if the ward did not have any patient who required a side room, patients who were receiving end of life care were then allocated side rooms whenever possible and if it was their wish.

The multi-faith room provided a place of worship, quiet time and prayer for people of all faiths and none. Prayer mats and religious texts were available for Christians, Jewish, Hindu, Sikh, Buddhist and Muslim religions.

Mortuary viewing facilities were appropriate and allowed relatives privacy. Viewing was usually arranged through the bereavement officer who accompanied relatives to the mortuary. Nurses were responsible for recording the deceased’s belongings and handing them over to the bereavement office. The bereavement office arranged for these items given to the relatives.
Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Link nurses, who had knowledge and expertise in specific fields, provided additional support to ward staff as required. For example, staff could request advice to help support patients with mental health or specific learning needs. Trust policies included an impact assessment to support equal access to service provision.

For those patients wishing to die at home, the discharge team arranged all aspects of their transfer home. This included any funding requirements, equipment to be provided, and their medication. They liaised with all the providers who would be involved in the patient's care post discharge and with their family.

Staff gave additional support to patients who needed it. For example, a senior nurse told us they had escalated a concern to a duty matron when an end of life patient’s behaviour became challenging and their family were distressed. In order to meet the patient’s needs, they were moved to a side room from the main ward to support the patient and their family. Nursing staff told us they provided increased monitoring to provide reassurance to the patient.

Wards were not designed to meet the needs of patients living with dementia. However, staff ensured that patients living with dementia were accommodated close to a nurse’s station. During our inspection staff said that adaptations were made when caring for patients living with dementia and relatives/carers were encouraged to bring familiar belongings to enable the patient’s individual needs to be met.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The hospital used a ‘This is me’ document for patients living
with dementia, experiencing delirium, or other communication difficulties. Staff encouraged family/friends/carers to support a patient with sharing information about their cultural and family background, their preferences and routines, and important events, people and places from their life.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Services were delivered and co-ordinated to be accessible and responsive to meeting the communication needs of patients with a disability or sensory loss. Staff were informed of a patient’s advance care plan (ACP) and preferred place of care during board rounds and nurse handover meetings.

The service had information leaflets available in languages spoken by the patients and local community. We saw these on the wards we visited. Leaflets gave information about community and advocacy services. The bereavement service patient information leaflet provided contact details of external bereavement support services, and the website link for end of life care information for relatives to access following the death of a loved one. Organ donation murals were located around the hospital and informed people about how sign up to the organ donor register. The artwork featured caricatures that took into account many religious beliefs/cultures. A patient information leaflet was given to relatives of deceased patients. This provided practical details about the formal process that was required after death and included information about collecting personal belongings. Furthermore, there was information about medication, nutrition and hydration, comfort and religious and spiritual care and facilities provided for families. Leaflets were available in other formats, for example in braille and other languages.

The trust did not have facilities in the mortuary for honouring spiritual and cultural wishes of the deceased person and their family and carers whilst preparing the body for transfer however, this could be arranged at the funeral director’s premises.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment. For example, information leaflets could be converted into an audio compact disc (CD) for people who had difficulty reading.

Staff had access to interpreters including for British Sign Language when needed.

The hospital’s spiritual and pastoral care team included chaplains, honorary chaplains and volunteers. Chaplains attended equality, diversity, inclusion training and supported patients, families and carers as well as staff, on request. Patients/families could request support from a tradition from the multi-faith team, such as Liberal Jewish, Christian Orthodox, Pagan, and Coptic Orthodox. A Roman Catholic clergy supported patient’s sacramental needs on request.

A Muslim prayer and a quiet room were available, and the chaplains held services representing a number of faiths in the chapel each week. Prayer leaflets and resources from a variety of faith and belief traditions and a prayer tree were available in the chapel.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff asked patients whether they had any cultural or religious preferences in food or drink. For example, staff confirmed a kosher or halal diet, for example, would be provided if requested.
Access and flow

Patients could access the specialist palliative care service when they needed it. However, it was not known if waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients identified as requiring palliative care, for example, symptom control, were referred to the specialist palliative care team (SPCT) by individual consultants or ward staff. The team carried bleeps for urgent referrals. A triage system was used for referrals and a ‘rag’ rating (a traffic light system) was used to prioritise the response required. The targets to see patients with a red rating was a four-hour response time; 12 hours for an amber rating; and three days for a green rating. From April 2018 to March 2019, 100% of patients referred to the service were assessed with the referrer by telephone within four hours, and 59% of patients were assessed in person. Clinical nurse specialists told us that an audit of referrals to the service had not been completed for more than two years. This meant there was no information to identify if patients had been allocated the appropriate rag rating to determine if they were accessing the service in line with agreed response times.

The hospital collated data to ensure the service met the needs of patients with a non-malignant diagnosis. From April 2018 to March 2019, there were 1,344 referrals made to the SPCT with 761 (56.6%) of these referrals being for patients with a diagnosis of cancer, 505 (37.5%) being patients with a non-malignant diagnosis, and 78 (5.8%) had an unknown diagnosis.

Ward staff told us the deceased were mostly transferred from the wards to the mortuary in a timely manner. Staff said that it could take longer for the porters to arrive and initiate the transfer of the deceased at night. The trust did not collect any information on how long wards had to wait for porters to arrive and transfer the deceased to the mortuary.

There was a formal process to identify end of life care patients admitted to the hospital. Patients at the end of their lives were identified in ward rounds and multi-disciplinary meetings and information was shared at daily safety huddles. This ensured patients accessed appropriate end of life care and treatment.

The SPCT provided a seven-day service between 9am and 5pm, and out of hours cover was provided by palliative care nursing/consultants working from a local hospice.

Managers and staff did not consistently work to make sure patients did not stay longer than they needed to.

The service did not consistently audit the number of patients who reported and those who achieved their preferred place of death (PPD) or analyse why this may not have been achieved.

The SPCT annual report April 2018 to March 2019, reported that the last audit was completed from January to March 2017. Only 32% of 78 patients were able to choose or state their PPD and, where PPD was known, this was achieved for 70% of cases. As the audit had not been completed for over two years, there was no assurance that patients achieving their PPD was in line with good practice. The July 2019 end of life care steering group minutes recorded that PPD was not routinely recorded for patients not known to the SPCT. An action plan was in place for documentation to be reviewed however, no target date for completion was provided.

The service aimed to focus on advance care planning earlier in a patient’s end of life journey, and to improve the sharing of information between services during 2019/20. Advance care plans are used to record a patient’s care and treatment wishes.
Managers monitored that patient moves between wards/services were kept to a minimum. Patients were moved only when there was a clear medical reason or in their best interests. Ward managers reported that patients at end of life were not moved unless in exceptional circumstances or if it was in their best interests. For example, if a side room had become available on another ward that would better meet their needs.

Managers and staff worked to make sure that they started discharge planning as early as possible. The integrated discharge team worked with the SPCT team and/or ward staff to support discharge planning. SPCT staff attended multi-disciplinary meetings with key partners, which enabled early plans to be made should a patient wish to be discharged to a hospice, for example.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Patients with urgent mental needs were referred and seen by an appropriate mental health clinician and assessed in a timely way.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff told us that when patients required a rapid discharge home, they worked with staff in the community to achieve this. The trust had not completed any recent audits of fast track or rapid discharge patients at the end of their life. They were therefore uncertain as to the responsiveness of the process as they did not have a baseline from which to assess improvements.

Staff supported patients when they were referred or transferred between services. The bereavement team provided a compassionate and responsive service to bereaved families and provided further advice as required. It was understood certain religions required their deceased relatives were buried as soon as possible after death. In such circumstances, the team tried to ensure all the relevant processes were completed as soon as possible so the family could register the death promptly.

Managers did not monitor patient transfers to ensure national standards were followed. Staff worked with the rapid discharge team and external providers, such as hospices, to assist with transferring patients in a timely way. However, the rapid discharge guidance was being updated at the time of our inspection, and there had been no recent audit to identify if there had been delays in discharge or transfer that may have impacted on a patient achieving their preferred place of care or death. The trust told us an audit would be completed once the guidance was updated in the ‘forthcoming year’ however, no target date was provided.

Staff did not move patients between wards at night. We reviewed five records to assess whether patients were moved between wards at night and found no patients had been moved.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff told us that they would attempt to resolve any complaints or concerns informally in the first instance and would then escalate to a more senior member of staff or to the Patient Advice and Liaison Service.
The service clearly displayed information about how to raise a concern in patient areas. Posters detailing how to make a complaint were displayed on the unit and throughout the hospital. The trust website had a section on how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff knew how to support patients and their families if they wished to complain. Staff referred to the complaints policy on the trust intranet.

Managers investigated complaints and identified themes. Staff told us complaints and learning were shared and discussed at handovers and staff meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us how they would follow the trust policy when responding to complaints and try and resolve concerns themselves whenever possible. All complaints were escalated to a ward manager who ensured they were investigated and that patients were kept informed of the stage of an investigation and its final outcome.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints was an agenda item on the end of life care steering group to enable emerging themes to be shared and cascaded to wards. Staff gave examples of how practice had been changed following a complaint. For example, mortuary staff told us a new system was initiated following feedback from funeral directors that calls had not always been answered.

**Summary of complaints**

**Trust level**

From April 2018 to March 2019, the trust received two complaints in relation to end of life care at the trust (0.2% of total complaints received by the trust). The trust took an average of 19.5 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 35 working days.

One of the complaints related to access to treatment or drugs and the other related to admissions and discharges (excluding delayed discharge due to absence of care package).

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

From April 2018 to March 2019, there were no compliments about end of life care at the trust.

The trust stated that compliments were received via the CEO office, these were responded to and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust was developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.
Is the service well-led?

Leadership

Leaders understood issues the service faced but did not always manage priorities effectively. However, they had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Direction of the service and its leadership had deteriorated since our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, when the nurse and consultant lead roles in the specialist palliative care team (SPCT) became vacant during 2018. This led to a review of end of life care service within the trust and hospital and the management of end of life care moving to the responsibility of the cancer directorate, alongside palliative care in November 2018. At the time of our inspection, a locum consultant clinical lead and deputy head of nursing (DHN), with a focus on end of life care had been appointed, although the DHN had only been in post for three weeks at the time of our inspection. The lead consultant position was a joint appointment with a local hospice, which enabled full oversight of community, hospital and hospice service provision. The senior leadership gaps in 2018 however, meant there had not been enough leaders with the skills and abilities to run the service. This led to gaps in the consistent identification of actions required to maintain quality and sustainability. A gap analysis had been completed and, at the time of our inspection, leaders understood the challenges to the service and actions required to address them. However, they had not embedded plans to prioritise them effectively.

Leaders did not consistently develop priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was an organisation wide end of life care steering group which aimed to develop service priorities. Leaders recognised the gaps in service provision, had reviewed the steering group agenda, and had increased the frequency of meetings from quarterly to monthly to address deficits in the service. However, priorities were not clear or consistently developed and progress to achieve them was slow. For example, with delivering end of life care training, and the development of a dashboard to capture performance data in one place. The leadership strategy included succession planning; for example, a lead palliative nurse role was being considered in place of a palliative consultant role due to a national shortage of palliative consultants. Locum palliative consultant positions had been extended to ensure continuity with developments in the service.

The specialist palliative/end of life care team was a strong group with an emphasis on providing consistent and high-quality care. Senior nurses we spoke with were positive about the end of life care leadership team. Staff from all specialities said end of life care had become more of a priority for the hospital during 2019.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of end of life care. Leaders were visible and available to staff, and we heard about good support for all members of staff on the wards.

There was an executive board member with responsibility for end of life care and a non-executive board member had been identified to support the service.
Patients and their families were at the centre of the service. There was an emphasis on the importance of education and awareness for patients and their families about dying and for staff across the trust to support them to have difficult conversations.

Vision and strategy

The service had a vision for what it wanted to achieve and a new strategy to turn it into action was being developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them however, did not always monitor progress effectively.

Staff told us the service vision was to make end of life care a trust-wide responsibility and to provide good quality end of life and palliative care. The trust had a palliative and end of life care strategy May 2017 to March 2020. A trust-wide, draft end of life strategy for adults was under development within an end of life care strategy group, and was planned to be available in January 2020. The strategy 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).

The group had a quality development plan in place, 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. Whilst there were clear plans in place, progress against the plan and target dates were not always clear. For example, it was aimed to train a group of staff in the emergency department in end of life and palliative care. No progress had been achieved against the April 2018 completion target, and a June 2019 review of the plan reported that a business case was under development. No future target date was provided for its completion. End of life care training was planned to be reintroduced as mandatory training as a priority within the overall strategy. This was first discussed in December 2018 and, a July 2019 review, confirmed on-line training continued to be discussed with the education team; however, no revised target date was given. Some areas of the development plan had progressed or had been met, and leaders across the service were motivated to ensure the future strategy met the overall vision of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

It was apparent during our inspection all the staff had the patient and their families at the centre of everything they did. They were passionate about end of life care and were dedicated to their roles and approached their work with flexibility.

The specialist palliative care/end of life staff were positive about their roles and felt supported to deliver end of life care to patients admitted to the hospital. The team was highly regarded by ward staff we spoke with and it was clear their work was important to them and they felt passionate about their contribution to deliver end of life care. The team worked closely with the wider
multidisciplinary teams, wards, departments, the chaplaincy and bereavement teams, and the local hospice. There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Ward-based staff we spoke with regarded end of life care as a priority. We saw interactions between staff and patients nearing the end of their life, which demonstrated respect and compassion. All the staff we met said they felt valued, confident and proud of the care they provided for those approaching the end of their lives. They felt supported by the leadership team and their colleagues.

The bereavement team was clear about their role in supporting relatives during a difficult time. Staff were professional and supportive and gave appropriate information to the bereaved in a manner that allowed them to ask questions. The team worked closely with the end of life and specialist palliative care team and the chaplaincy service.

It was evident that mortuary staff carried out their role with respect for the deceased and those close to them. Staff took pride in their job and were clear about their role in enabling relatives and friends to say their final goodbyes with their loved one, and the impact this may have on their grieving process and ongoing life.

Managers encouraged learning and a culture of openness and transparency. Staff said they were encouraged to speak up and felt comfortable about raising any concerns with medical staff and their line manager.

Staff were aware of the trust freedom to speak up policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the freedom to speak-up guardians.

**Governance**

Leaders did not operate effective governance processes throughout the service and with partner organisations. There were not consistent discussions to support learning from the performance of the service. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet.

The service had systems and processes to improve the care they delivered however, they were not effective. At the time of our October 2015 inspection, governance within the service was not effective. Audits had not been completed in line with national standards. During this inspection, we found staff members were clear about their roles and accountabilities to provide a quality service that met patient’s needs. However, we found that whilst governance arrangements were in place to provide oversight of quality and safety performance, we were not assured they were sufficiently effective in maintaining standards consistently. For example, in ensuring staff compliance with end of life care training, syringe driver training, audit completion, and with ensuring all incidents were reported. Furthermore, the audit framework and action plans to drive up service improvement were not robust in ensuring they were honouring patients’ wishes, or if they needed to improve this. This represented no change from our October 2015 inspection. Furthermore, an inspection of end of life care services at another trust site, Mount Vernon Cancer Centre, in November 2018 found that the service was in breach of the Health and Social Care Act 2008 (Regulated Activities), as it did not consistently evaluate and improve the quality and safety of practice. Systems for supporting
governance arrangements such as oversight of incidents, risks and complaints were not effective as information was sometimes missing and escalation processes were unclear.

During this inspection, we found clinical and divisional directors attended monthly directorate meetings where senior managers discussed performance, risk, governance and human resources. Clinical governance issues were discussed at quarterly specialist palliative care clinical governance meetings and at the monthly end of life care steering group. There was some discussion of clinical quality, patient safety and patient experience however, the record of discussions and agreed action plans did not assure us all levels of governance functioned effectively. For example, the steering group meeting agendas did not always correspond with items discussed in the minutes; not all allocated actions had target/feedback dates; and some ‘carried forward’ items did not appear on the following month’s agenda. The April 2019 minutes included an agenda item for incidents when it was discussed that all end of life/palliative care incidents should be reported on the trust electronic reporting system. Incidents was not an agenda item in the subsequent June or July 2019 end of life care steering group meetings. It was also reported in the April 2019 meeting that a review of service risks would be discussed at the following meeting. This action was not taken forward and risks in the service did not appear as a regular agenda item. Furthermore, whilst training was discussed in the April 2019 meeting and it was recognised performance improvements were required in the delivery of end of life care/syringe driver training, there were no clear action plans with target dates for completion. Progress had not been achieved three months later and the July 2019 end of life care steering group minutes noted an action for all band 7 nurses and above to undertake syringe driver training within four weeks. No reference to the training was made for band 5 and band 6 nurses, and we were not assured governance processes supported the effective oversight of training needs.

The service monitored a set of performance measures however, performance reports were not always clear. For example, the palliative and end of life education report 2018/9 reported the number of staff who had engaged in various training days. This included preceptorship training for band 5 nurses, and numbers of staff who had completed syringe driver training. The figures did not include a breakdown of eligible staff which meant it was not possible to measure performance against a target figure or identify how many staff had not received training. The specialist palliative care team (SPCT) annual report April 2018 to March 2019 did not contain clear performance information. For example, it was reported that improvements were required in advance care planning and stated a re-audit was due to determine if service improvement was required. However, no date was provided for this to be actioned. Furthermore, it was reported that the integrated discharge team were working with the SPCT to develop rapid discharge home guidance. There was no timescale for completion and the action stated this would be in the ‘forthcoming year’. The trust’s end of life care steering group did not contain a standard agenda item for audit updates or action plans with completion targets.

An end of life care presentation was delivered by nurse leads in the July 2019 trust board meeting however, no specific performance data was made available. Furthermore, we found no evidence that specific end of life care performance data was presented within the January, March, May 2019 or November 2018 board meetings. There was some discussion about future service developments in the majority of meetings however, there were no set timescales for project completion or trajectories made available. For example, in the November 2018 board minutes it was discussed that future ‘milestones’ included a team of end of life/palliative care trained staff in the emergency department; the introduction of treatment escalation plans; and a stronger focus on
the end of life strategy group. At the time of this inspection, seven/eight months following the board meeting, progress had not been achieved or was slow in these areas. With the absence of a non-executive end of life/palliative care board member, we were not assured sufficient challenge had been made to ensure effective governance arrangements were in place.

The service had developed an audit programme to monitor and assess performance in line with national guidance and standards. However, not all audits were completed when required to support the effective sharing of performance measures from ward to board level. Monthly end of life metrics were reported to the board which included the specialist palliative care input, percentage of deaths with a hospital admission in their final 90 days, percentage of hospital admissions ending in death where the length of stay was eight days or more, and time spent in hospital in the last six months. However, not all internal audits were completed in line with national guidance or standards which meant results could not be monitored with action plans to address concerns.

End of life care matters were covered by the mortality and morbidity group. However, governance arrangements did not support the effective cascading of learning. Minutes of mortality and morbidity reviews demonstrated that there was learning from incidents. However, learning outcomes were not effectively shared with staff across the service. Managers had recognised in April 2019 (as cited in the steering group minutes) that there was not a systematic way of cascading information however, there was no evidence that action had been taken to improve arrangements. The minutes recorded, ‘…there were the same issues for the last five years and nothing has changed’.

The trust participated in the National Audit of Care at the End of Life (NACEL) for 2018/2019. This audit enabled oversight of the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The information was presented thematically in nine sections, covering the five priorities for care and other key issues. The report was available to the trust but had not been published. A summary score infographic was provided for each theme within the report. The trust’s average score was better than the national average score of 9.1 and the scores were better than the national average in all but two themes relating to the communication with the dying person and the workforce/specialist palliative care. This was an improvement in results from previous national audits. The team were working on an action plan to address the shortfall following the publication of the results and recommendations in July 2019.

The trust had continued to address the previous shortfalls from the National Audit of Care at the End of Life (NACEL) for 2015 and an action plan had been monitored at local working group meetings.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At the time of our October 2015 inspection, which was the last time this service had been inspected by the Care Quality Commission, the specialist palliative care team (SPCT) did not have oversight of risks to their services, such as do not attempt cardiopulmonary resuscitation. There
was no risk register specific to palliative/end of life care. Furthermore, an inspection of end of life care services at another trust site, Mount Vernon Cancer Centre, in November 2018 found that the service was in breach of the Health and Social Care Act 2008 (Regulated Activities), as systems and processes did not support the consistent assessment, monitoring and mitigation of risks.

During this inspection, we found there was an end of life/palliative care risk register which defined the severity and likelihood of risks causing harm to patients or staff. Risks were categorised as extreme, high, medium, low, and scored accordingly. There were two risks entered on the risk register as a moderate risk that related to the availability of syringe drivers; and the recruitment of palliative care consultants. We observed the risks were regularly reviewed and mitigation was taken to reduce the risks. For example, a system to sign syringe drivers in and out of the equipment store had been put in place; and job role reviews were completed in collaboration with key stakeholders to mitigate the risks associated with a national shortage of palliative care consultants. However, we were not assured all identified risks were reported on the risk register, such as syringe driver training requirements, end of life care training, staffing resource, reporting of incidents, electronic palliative care coordination system (EPaCCS) training, and completion of audits. It was noted in the April 2019 end of life care steering group minutes that a ‘deeper dive’ of risks associated with end of life care would be explored at the next meeting. There was no reference to risks or an agenda item in the June or July 2019 minutes however, which meant we were not assured risks were identified and escalated, and that there was mitigation to reduce their impact. This represented no change since our October 2015 and November 2018 inspections. There was effective board oversight of performance regarding antimicrobial prescribing. Action had been taken to remove certain medicines from the formulary.

The mortuary had an action card which outlined actions to take in the event of a major disaster such as mass loss of life and incidents that involved the release of chemical, biological or radioactive materials.

Staff contributed to decision-making and worked with the end of life care discharge liaison team who organised the discharge of patients at the end of their life to their preferred place of care. This often needed to be done quickly if they were to get the patient to their chosen place to die.

**Information management**

**Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements; the information systems were not integrated. However, systems were secure and data or notifications were consistently submitted to external organisations as required. The service collected reliable data and analysed it.**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Paper-based information and electronic information about patients were stored securely.

Staff had access to information they required to provide good patient care however, service developments were ongoing to improve access to information. Staff we spoke with were familiar with the trust intranet and knew where to find the information they needed. End of life care folders were available on wards with comprehensive information and guidance to deliver end of life care. There was guidance for staff in completing treatment escalation plans and resuscitation decisions, and the fundamentals of nursing care for end of life patients.
Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment. Staff used electronic systems to manage patient information such as referrals to the specialist care teams and to gain access to information about results of investigations such as blood tests. The service had installed the national electronic palliative care coordination system (EPaCCS) to capture compliance with national standards however, staff had not received the required training to allow use of it at the time of our inspection. Not all end of life care patients were identified on electronic patient records on admission to the emergency department or on inpatient wards through use of the correct alert. This meant it may not always be clear to staff that a person had been identified as an end of life care patient.

There were many spreadsheets/forms to capture performance data stored within electronic records. Staff told us an end of life care dashboard was under development to support the sharing of information across the service and wider network. It was planned this would be available by the end of September 2019.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The team held engagement events in the local community and within forums such as dying matters awareness week 2019 to talk about advance care planning to encourage people to consider their plans at the right time.

Patients could provide their feedback inpatient surveys, social media, NHS Choices, postal surveys, face-to-face engagement, PALS/complaints and the NHS friends and family test.

There were patient feedback forms and alternative communication formats such as audio tape/computer disc, Braille, large font, high contrast, British Sign Language, easy read, and translated versions.

The Butterfly volunteer service engaged with community services to fundraise and enlist new volunteers in the service. They also shared their success with other trusts who wished to introduce a similar scheme.

The hospital worked with GPs and community nursing teams to facilitate discharge of patients. There was a designated coordinator to organise discharge for patients nearing the end of their life. They had a close working relationship with community-based healthcare teams to enable patients to be discharged home.

The bereavement team met with relatives of deceased patients when collecting the medical certificate cause of death, which was required to register the death with the Registrar of Births and Deaths. During this meeting, relatives were handed a bereavement booklet which contained practical advice and information about additional support such as the chaplaincy service. Bereavement staff offered the opportunity for relatives to raise any questions or issues connected to the care of their loved one.

The trust engaged with key partners to encourage people to talk to their families about organ donation and help increase the number of lives saved or transformed by a transplant. Organ donation week was held in September 2018 when information stands, and advice was provided in the entrance corridor in the hospital.
The trust supported the ‘Dying Matters’ week in April 2019 to raise awareness and to provide advice to the public and local professionals about dying, death and bereavement. End of life staff from the trust and key stakeholders, including lawyers, provided information in the main entrance of the hospital. The event enabled people to have increased awareness of how to plan for ‘end of life’ in a more positive and sensitive manner.

There were ward champions for end of life care. These were members of staff with a specialist interest in end of life care and who had been provided with additional support and access to training. Staff on the wards we visited confirmed they had end of life champions and knew who they were.

The end of life and specialist palliative care team engaged with staff working in different directorates across the trust. Education was provided to staff across the hospital to staff who worked in different directorates. This was either on an individual basis to provide ward staff with specialist support in meeting patient needs, or in group training sessions provided at intervals to staff working in different roles and directorates across the hospital.

There were effective systems to engage with staff. There were regular staff newsletters on the wards and across the division where information was shared.

Staff had access to health and wellbeing services. Counselling services for staff were available through the occupational health service. The chaplain provided support for staff including a weekly wellbeing session.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. However, consistency with completion of audits and improvements with cascading information within meetings was required to ensure continuous development was achieved.

The divisional leaders and ward leaders took action to make improvements in the running of the service. They had regular meetings where learning was discussed in a variety of forums. For example, matrons’ meetings and end of life care steering group meetings.

There were areas of improvement since the last inspection, which included:

- Significant improvement was achieved in the accurate completion of do not attempt cardio-pulmonary resuscitation (DNACPR) forms
- The DNACPR forms had been updated and contained communication and capacity of the patient sections
- Staff had access to patient’s medical records on admission and an alert for end of life care patients was introduced to alert the palliative/end of life care team.
- An end of life care button was introduced to the electronic incident reporting system which had improved oversight of incidents
- End of life care transferred to the cancer division to ‘sit’ with the palliative care team. This aimed to provide improved governance of end of life/palliative care services.
• A new deputy head of nursing with a focus on end of life care was appointed in July 2019.
• A Butterfly volunteer service was introduced and provided volunteers to comfort a patient and provide support to families/carers in the last hours of life.
• Electronic discharge summaries allowed GPs to have information about their patient emailed straight to them to assist with rapid discharge.
• Treatment escalation plans had been introduced and were being piloted to ensure teams had conversations with patients and families at the earliest opportunity.
• Ward of the week training had been introduced to provide a ward with a week of workshops/training and updates in end of life care, communication, documentation.
• The Butterfly volunteer service had been awarded additional three-year funding and aimed to expand the number of available volunteers. The service won an NHS 70th birthday parliamentary award in 2018 in the care and compassion category.

However, further developments were required to ensure end of life care performance measures were part of the organisation’s dashboard. The delivery of a consistent, rolling training programme was required to ensure staff remained up-to-date with end of life care policies and procedures.
Outpatients

Facts and data about this service

The outpatients team provide nursing and administration support to the outpatient clinics based at Lister, Queen Elizabeth II (QEII) and Hertford County Hospitals. The trust also supports some community-based clinics. In addition, Mount Vernon Cancer Centre (MVCC) supports an outpatient service for the cancer services provided on that site. This report concerns outpatient services at Lister Hospital, however, some data refers to outpatient services across all the trust’s outpatient services.

(Source: Routine Provider Information Request (RPIR) – Context acute)

Total number of first and follow up appointments compared to England

The trust had 611,317 first and follow up outpatient appointments from February 2018 to January 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from February 2018 to January 2019.
<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lister Hospital</td>
<td>520,587</td>
</tr>
<tr>
<td>Queen Elizabeth II Hospital</td>
<td>161,533</td>
</tr>
<tr>
<td>Hertford County Hospital</td>
<td>76,332</td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>75,291</td>
</tr>
<tr>
<td>*East and North Hertfordshire NHS Trust</td>
<td>2,933</td>
</tr>
<tr>
<td>This trust</td>
<td>836,694</td>
</tr>
<tr>
<td>England</td>
<td>108,838,071</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from February 2018 to January 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at East and North Hertfordshire NHS Trust from February 2018 to January 2019 by site and type of appointment.

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

There are consultant and nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients’ department. Outpatient clinics are held Monday to Friday from 8.30am to 5.30pm. There were some outpatient clinics provided on weekends. The outpatients’ service is part of the clinical support services division. The current structure includes a divisional chair, a divisional director, and a head of nursing.

We inspected the service on 23 to 25 July 2019. We visited all the outpatient clinics taking place on those days in the outpatient department at Lister hospital.

During the inspection, we spoke with 26 staff of various grades including nurses, pharmacists, consultants, junior doctors, clinical support workers, and reception staff. We spoke with 12 patients, observed care and treatment and looked at 10 patient’s care records. We received
comments from people who contacted us to tell us about their experiences, and reviewed performance information about the service. The service was last inspected in 2015. At that inspection, it was rated good overall.

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 made sure everyone completed it.

Mandatory training completion rates

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

Lister Hospital

Nursing staff received and kept up-to-date with their mandatory training. Staff had access to mandatory training in a range of subjects including health and safety, fire safety, infection prevention and control and manual handling.

Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>27</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control- Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>26</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>25</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>24</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>22</td>
</tr>
</tbody>
</table>

At Lister Hospital outpatient department, the 90% target was met for six of the eight mandatory training modules for which qualified nursing staff were eligible. Fire safety was just below the
compliance target and nursing staff that had not completed information governance had been booked onto the e-learning sessions.

Medical staff received and kept up-to-date with their mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for six of the seven mandatory training modules for which medical staff were eligible. This is applicable only for the medical staff that worked in dermatology clinics. The other medical staff training data is not shown because these staff work within the medicine or surgical directorate. The medical staff we spoke with during our inspection had up to date mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Training information for all staff was available through the trust’s ‘knowledge centre’. Training data was available at departmental level, additionally, staff could access their own training records and received reminders when updates were required.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This training was covered in their safeguarding sessions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training uptake was reported and monitored across the division by the matron; staff were encouraged to take responsibility for completing mandatory training themselves. They were sent reminders by email to ensure they completed it on time.

**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.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.
Lister Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. Staff had regular training in safeguarding of vulnerable adults and child protection. Those interviewed were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at Lister Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>26</td>
</tr>
</tbody>
</table>

At Lister Hospital outpatient department, the 90% target was met for all four safeguarding training modules for which registered nurses were eligible.

Trust level

Medical staff received training specific for their role on how to recognise and report abuse. There was no data provided for medical staff for this core service, apart from the dermatology consultants. However, three of the consultants we spoke with were trained to level 3 safeguarding children and all had level 2 safeguarding adults.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>3</td>
</tr>
</tbody>
</table>

In outpatients the 90% target was met for all four safeguarding training modules for which medical staff were eligible.
Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Nursing staff could give us examples of identifying any patients at risk. Some staff even went further and explained it was about protecting their work colleagues and recognising if they were at risk too. They told us the process that they would follow.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff told us that the training gave them skills and tools to identify adults and children at risk of harm. There was a good working relationship with the safeguarding lead for the hospital, additionally staff spoke with the patients GPs if needed or if they had any queries. For any formal referrals staff knew how to access the correct referral forms and who to ask for advice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Both nursing and medical staff we spoke with knew how to make safeguarding referrals and could direct us to the relevant information they used for reference. A trust-wide safeguarding vulnerable adults and children policy was in place, which covered all aspects of safeguarding, including female genital mutilation. The policy was accessible to staff electronically.

Information on safeguarding was seen on staff noticeboards and in public areas with relevant contact numbers.

Staff followed safe procedures for children visiting the department. Children’s clinics were scheduled separately from the adult clinics and in appropriate areas. There were very few children that attended the main adult outpatients’ department at Lister Hospital.

Cleanliness, infection control and hygiene
The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Regular environmental and hand hygiene audits were conducted in the department. For June and July 2019, they were at 100% and 90%, against a target of 90%. Staff complied with uniform policy; all staff in all areas were arms bare below elbows, long hair was up or tied back and we observed staff used hand gel.

Nurses cleaned clinical equipment in the clinic rooms daily and we saw that cleaning schedules were signed and dated to evidence this. Staff told us cleaning of the environment (floors, furniture and high reach areas) was outsourced to an external company, who followed cleaning checklists and carried out audits of completion of tasks against the checklist. All staff we spoke with were satisfied with the cleanliness of the clinical environment. All observed seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears. Floors, seating, couches, and children’s toys provided in waiting areas were all wipe clean in line with the trust infection prevention and control policy.

The nursing staff used a standard three-stage wipe system for naso-endoscopes to decontaminate equipment between patients in the ear nose and throat clinic, as this was not disposable equipment. This was in line with national guidance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw evidence of cleaning records for each area. These were all completed and signed for the
month of June 2019. Toilets were clean and well equipped with sufficient hand washing gels and paper towels.

Staff followed infection control principles including the use of personal protective equipment (PPE). Consulting rooms had disposable aprons, gloves in various sizes; paper towels; disposable bed sheets; hand sanitiser; and suitable clinical waste disposal.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The department operated a system of using dated green stickers on all equipment and furniture in treatment rooms to indicate that they had been cleaned every day. We saw examples of this and all stickers were in date.

Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot operated lids. Bins were not overfilled.

Cleaning staff were observed using colour coded cleaning equipment in line with trust guidelines.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The outpatients’ department was located off the main corridor not far from the main entrance. It was all on one level and had different areas for each clinic.

Staff carried out daily safety checks of specialist equipment. Staff were specifically trained to do this. We saw evidence of their signed competencies. Electrical safety checks had been carried out on mobile electrical equipment and labels were attached which recorded the date of the last check.

The service had enough suitable equipment to help them to safely care for patients. Nursing staff told us they had enough equipment to carry out specific tests for patients. There were hoists and wheelchairs available for when they were needed.

Staff disposed of clinical waste safely. There were arrangements for managing waste and clinical specimens; for example, segregation, labelling and handling of waste where appropriate. We saw that there were arrangements in place for managing specimens, such as blood samples, taken in the phlebotomy department. The process included confirming the patient’s identity and correct labelling of blood bottles.

We checked the resuscitation trolleys located throughout the departments. The trolleys were secure and sealed. We found evidence that regular checks had been completed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, World Health Organisation safe surgery checklists were not used for invasive procedures in urology at the time of the inspection but were being developed.

Staff responded promptly to any sudden deterioration in a patient’s health. A trust policy was in place to identify a deteriorating patient; staff told us they would call the ‘crash’ team where
required. During our inspection we saw evidence of the medical and nursing staff responding to a patient who became unwell with chest pain. They responded promptly and carried out the correct and necessary care for this patient. There were clear pathways and processes for the assessment of people within outpatient clinics or who were clinically unwell and required hospital admission. Staff were trained in life support techniques and had access to emergency resuscitation equipment. Resuscitation trolleys all contained adult and paediatric emergency equipment. Doctors were available within clinics to assist in the event of medical emergencies. There was an emergency internal phone number to call if a patient had a cardiac arrest and required a specialist team to provide advanced life support.

Staff received training on the ALERT course, this gave nurses and health care assistant knowledge of the deteriorating patient. Additionally, they completed NEWS2 training. NEWS is the national early warning score, a score is made once a patient’s blood pressure, heart rate, respiratory rate and temperature had been recorded to recognise and act upon early signs of a patient deteriorating.

Staff completed risk assessments for each patient on arrival in the department and updated them when necessary using recognised tools. Outpatient staff completed risk assessments including national early warning score (NEWS), pre-assessment for procedures and pain assessments. These were recorded appropriately in the medical records and nurses escalated any concerns to medical staff in clinics. There were also additional risk assessments to be used for specific patients, including, moving and handling, pressure areas (Waterlow skin care assessments) and venous thromboembolism (VTE) or blood clots.

Staff knew about and dealt with any specific risk issues. The World Health Organisation (WHO) ‘Five steps to safer surgery’ checklist was used for patients undergoing minor procedures or injections, for example in ENT and urology. The checklist is a five-step process which involves briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures. However, we were told that the department did not formally have this in place. We were told that the team carried out the steps including; team introduction, patient identification process, check for allergies, consent and correct site check were performed. However, patient identification was only done verbally, and no identity bands were used to ensure the correct patient was undergoing the procedure. Although there were standard operating procedures for the procedures, no formal checklist template was used in urology or ENT. During the inspection, we asked if there were any local safety standards for invasive procedures (LocSSIPs) in place to build on the existing WHO surgical checklist and promote the effective performance of the five steps to safer surgery guidance, and we were told these were currently under development across the trust and would be incorporated into the safer surgery collaborative. Organisations should review and develop local processes for invasive procedures, or LocSSIPs, to ensure practice is compliant with the national safety standards for invasive procedures (NatSSIPs) set out by NHS England in 2015.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they knew there was a mental health liaison team who could assess and support patients’ mental health. They were based in the emergency department and staff knew how to access them. Staff in the department told us they were aware of the service’s major incident plan.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The medical staff took the lead in completing psychosocial assessments and make the necessary referrals.
Staff shared key information to keep patients safe when handing over their care to others. In the department, there was a daily safety huddle to review staffing and any concerns about the clinic running that day. This included discussions about any complex patients or issues with equipment.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. We spoke with senior staff to establish how staffing requirements were ascertained, as there are no national standards or guidelines for how outpatient clinics should be staffed. They told us this was done on the demand of clinics mapped for each day. Staffing was planned in advance with the aim to always include qualified nurses to coordinate the clinics. We saw from staffing rotas, that this was the case. We observed that there were reception and nursing staff available to support all clinics that were running during the inspection.

The department used no agency staff. Where staff numbers were less than required bank staff were used.

Sickness was managed well by the senior sister, there were regular reviews of sickness, and these were clearly documented alongside outcomes of meetings and discussions. Staff were referred to occupational health and phased returns were offered to help them back into work.

All new staff received a local induction to each area on their first shift.

**Lister Hospital**

The table below shows a summary of the nursing staffing metrics in services for outpatients at Lister Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>123</td>
<td>0%</td>
<td>15%</td>
<td>4.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>25</td>
<td>11%</td>
<td>19%</td>
<td>3.0%</td>
<td>733</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service Lister Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness. The trust also reported that no agency hours were used in outpatients.
Vacancy rates
The service had reducing vacancy rates.
From April 2018 to March 2019, the trust reported a vacancy rate of 11% for qualified nursing staff in outpatients. This was higher than the trust’s overall target of 6%. However, during the inspection period the vacancy rate had reduced to 5%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
The service had a high turnover rate.
From April 2018 to March 2019, the trust reported a turnover rate of 19% for qualified nursing staff in outpatients. This was higher than the trust target of 10.5%.

Sickness rates
The service had low sickness rates.
From April 2018 to March 2019, the trust reported a sickness rate of 3% for qualified nursing staff in outpatients. This was lower than the trust’s target of 3.4%.

Medical staffing
The service had enough medical staff to keep patients safe. Medical staffing was provided to the outpatient department by the various specialties that had clinics. Doctors who worked in outpatients were associated to the various core services rather than the outpatient department, so this data was not collected or monitored by the outpatient department.

Medical staff undertaking clinics were of all grades; however, we saw that there were usually consultants available to support lower grade staff during clinics.

Medical staff were asked to give six weeks’ notice of any leave in order for clinics to be managed or adjusted.

Medical staff gave two weeks’ notice to add any ad hoc clinics to their list; this was so that staff in outpatients could coordinate rotas accordingly.

The trust told us that locums were rarely used.

Records
Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, medical records were not stored securely within the clinics, they were awaiting delivery of lockable trolleys.

Patient notes were comprehensive, and all staff could access them easily. Patients’ individual care records were managed, written, and stored correctly according to best practice. Records were a mixture of electronic and paper. Each morning the medical records were brought up to the department and stored in a locked room ready for the clinics. The senior staff reported no incidents when records were not available.

When patients transferred to a new team, there were no delays in staff accessing their records. The outpatients’ service communicated with GPs through letter. According to the NHS Standard Contract, a clinic letter should be issued to the patient’s GP within seven calendar days following
outpatient attendance (NHS England, *Guidance on the NHS Standard Contract requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems* (August 2018)). At the time of our inspection (July 2019), the trust did not monitor turnaround times for clinic letters to be issued to GPs. However, following our inspection we were told that there had been no incidents of major delays.

Records were not stored securely. We saw that when the medical records were taken out of the locked room to be distributed to the clinics, they when kept in boxes outside each consulting room. These could not be locked. The senior staff had recognised this, and lockable storage trolleys were on order and were due to be delivered in August 2019. To mitigate any risks, staff were always present, and the boxes were not left near any patient waiting areas.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. There were effective systems in place regarding the handling of medicines. Outpatient nursing staff did not administer medicines but consultants and the clinical nurse specialists working in the clinics did use some medicines for injection, such as local anaesthetic and steroids. They followed the trust’s, and national guidance for these.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. On occasion, nursing staff in some clinics were asked to teach patients self-injection techniques for blood thinning medicines if they were at risk of a blood clot. In this situation, the consultant would issue a prescription which was collected from the hospital pharmacy by the patient, who then returned to the clinic for advice. Nursing staff provided advice and a written information booklet about the injections. In addition, the patient’s injection technique was observed to ensure they were competent. If there were any concerns about competence, patients were referred to their GP, practice nurse, or a district nurse. Staff could seek advice and support regarding medicines from the pharmacy department, if necessary.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Room temperatures and refrigerators were monitored in areas where medicines were stored. The temperatures were recorded daily sheets which logged the actual temperature and the maximum and minimum temperature that the data logger had recorded over the previous 24 hours. The sheets showed clearly if the temperatures were ‘OK, too warm, or hot’ and listed actions to take if temperatures recorded were out of an acceptable range. Temperature records were documented on most clinic days in most areas, and that medicines were generally stored within the recommended temperature range for safe medicine storage.

In all clinics visited, we found medicines and medicines’ related stationery, such as prescription pads, were managed safely. We found that all treatment rooms were secure, requiring a key, key code or pass to enter. All cupboards containing medicines were locked within treatment rooms. Prescription pads were ordered from pharmacy and kept within the locked cupboard in small quantities. There was a log indicating the number of each prescription sheet used, date, patient’s name, prescriber, medicines type and quantity prescribed. The log sheets were checked weekly by two nursing staff to ensure that there was no discrepancy.
The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. If there were any national medicines safety alerts, these were disseminated to the department through the pharmacy team and shared.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had processes in place to prevent harm to patients and staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff described the process for reporting incidents and gave examples of when they had done this.

Staff reported all incidents that they should report. Staff told us that there was a positive incident reporting culture, that had improved since the last inspection in 2015.

**Never Events**

The service had no never events.

From June 2018 to May 2019, the trust reported no incidents that were classified as a never event for outpatients.

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

*(Source: Strategic Executive Information System (STEIS))*

Managers shared learning with their staff about never events that happened elsewhere. There had been five never events across the trust, but none in outpatients and staff told us these had been discussed at staff meetings.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients, which met the reporting criteria set by NHS England, from June 2018 to May 2019. One of the incidents was classified as a treatment delay, meeting SI criteria and the other was classified as a diagnostic incident, including delay, meeting SI criteria (including failure to act on test results). These SIs were not at the Lister hospital; however, learning had been shared to the staff.

*(Source: Strategic Executive Information System (STEIS))*
Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff told us they were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities relating to it.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff had feedback on incidents and action taken through staff meetings, team briefings and information on staff noticeboards. Staff working in the outpatient department told us that learning from incidents was fed back and disseminated through local meetings which were facilitated by the senior sister.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. All staff members had access through the intranet to the trust tool kit which contained relevant template letters and documentation. Duty of candour compliance was reviewed on a monthly basis at the serious incident review and learning group. Feedback in the form of a gap analysis was provided to divisional leads, to identify where further actions were required to support compliance and timeliness. All staff received training regarding duty of candour at induction. Clinical staff band 5 and above were also able to access root cause analysis training which covered duty of candour as part of these learning sessions.

Managers debriefed and supported staff after any serious incident. The senior sister told us that they would meet with staff individually for debriefs and feedback when needed.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. Staff collected safety information and shared it with staff, patients and visitors. This information was intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. The trust reported outpatient monthly RTT performance levels and ‘did not attend’ rates within each clinical area. The trust also reported the number of harm reviews completed and identified the number of cases that had led to patient harm.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had up to date policies and guidelines in place. Trust policies were readily available on the trust intranet system. Care in each clinic was provided in line with national guidance, for example, National Institute for Health and Care Excellence (NICE).
guidance. For example, staff in the fracture clinic had access to NICE guidelines; NG 37 and NG38. In Rheumatology clinic staff had access to guidelines such as CG177 and CG79. Trust policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age.

We saw evidence of patient care and treatment being planned and delivered in line with evidence-based guidance in the clinics, such as neurology, ENT and rheumatology clinics.

Specific pathway documents were used for each procedure, for example flexible sigmoidoscopies for outpatient clinics were carried out in line with professional guidelines, and staff used these pathways to ensure the equipment was used in the correct way.

Updated clinical guidance was reviewed at trust wide level and fed back to staff through the hospital’s clinical governance committees.

Patient clinical pathways were standardised through the outpatient division; these took into account guidance and established practice.

Staff protected the rights of patient’s subject to the Mental Health Act and followed the Code of Practice.

**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 needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. We noted that there were signs to hospital refreshment facilities in the outpatient department and there were small cafes and a shop nearby where patients could purchase food and drink. Water coolers and disposable cups for the patients were in outpatient waiting areas or jugs of water and paper cups where fountains were not available. Nursing staff told us they offered hot and cold drinks to patients who had spent a long time in clinics and were able to offer light snacks to those who were waiting for transport.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. There was access to specialist dietary and nutritional support in some clinics when needed. Nursing staff were able to contact dieticians and speech and language therapists who visited patients in the head and neck clinic to provide advice and support on eating, drinking and swallowing.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients we spoke with had not required pain relief during their attendance in the outpatient clinics. However, patients told us the consultants routinely asked them about their pain and pain management.

Staff prescribed, administered and recorded pain relief accurately. Nursing staff told us if a patient presented in pain, they would score it using the 1 to 10 pain score tool. They would then ask the
consultant or clinical nurse specialists, who were non-medical prescribers, in the patient’s relevant clinic, to prescribe an appropriate pain relief medication and record this in the patient records.

Patients were referred to pain management clinics if needed.

Patient outcomes

Staff generally monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service did not generally participate in local or national clinical audits. These were undertaken by medical and surgical specialities. Most specialities participated in national clinical audits, such as the Vascular Services Quality Improvement Programme (VSQIP), and National Prostate Audit. The outpatients service at Lister were in the top ten audit performers for the National Early Inflammatory Arthritis audit. This meant that they were one of the top trusts in recruiting patients for this audit. At the time of the inspection, the data had been submitted, but no results were back.

There was some participation in organisational audits, for example of hand hygiene and the environment. We saw the results of the environmental audit displayed outside each consulting room and main waiting areas.

Managers did not carry out a comprehensive audit programme. However, they audited outpatient performance measures that impacted on patient experience and outcomes, such as waiting times.

Managers used information from the audits to improve care and treatment. Measures such as referral to treatment times and other dashboard indicators were discussed at clinical governance and operational meetings and ways in which they could be improved were discussed.

Managers shared and made sure staff understood information from the audits. This information would be discussed at regular staff meetings.

Improvements were checked and monitored. The service had an outpatient dashboard which managers used to monitor referral to treatment times, ‘did not attend’ rates, clinic cancellations, slot utilisation and other key measures. The service also monitored clinical correspondence transcription times. This performance data was discussed at monthly meetings.
Follow-up to new rate

From February 2018 to January 2019:

- the follow-up to new rate for Lister Hospital was similar to the England average.

Follow-up to new rate, East and North Hertfordshire NHS Trust.

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

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 and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All clinics were run by clinicians with the appropriate experience and training in the field.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and support to complete local competencies.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. The breakdown by staff group can be seen in the table below:

Lister Hospital

From April 2018 to March 2019, 87.9% of staff within outpatients at Lister Hospital received an appraisal compared to a trust target of 90%. Nursing staff were at 88.0% due to two members of staff on long term leave.

The breakdown by staff group can be seen in the table below:
Staff group | April 2018 to March 2019
--- | ---
| Staff who received an appraisal | Eligible staff | Completion rate | Trust target | Met (Yes/No)
Add Prof Scientific and Technic | 1 | 1 | 100.0% | 90% | Yes
Additional Clinical Services | 14 | 14 | 100.0% | 90% | Yes
Healthcare Scientists | 3 | 3 | 100.0% | 90% | Yes
Nursing and Midwifery Registered | 22 | 25 | 88.0% | 90% | No
Administrative and Clerical | 62 | 73 | 84.9% | 90% | No
Total | 102 | 116 | 87.9% | 90% | No

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

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical nurse specialists said they had access to supervision and some spoke about attending group supervision sessions. Junior medical staff were allocated clinical and educational supervisors. They told us they were encouraged to attend training courses and were given time to undertake them.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were held monthly within the outpatient service and reception staff said they had team meetings three to four times a year. Notes of the meetings showed a wide range of issues were discussed related to improvements in the service and training completion.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their training and development needs were discussed at their appraisal.

Managers made sure staff received any specialist training for their role. Staff told us that had additional training for specific skills such as venepuncture (blood taking) and the use of the specialist equipment used in the urology clinics. Each member of staff, registered nurses and health care assistants had individual competency folders to complete and work through.

Managers identified poor staff performance promptly and supported staff to improve. The senior sister told us of previous management of poor staff performance, this had been identified and managed appropriately.

**Multidisciplinary working**

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

We saw that care was delivered in a coordinated way and that staff in different teams were involved in providing person centred care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All staff were invited to these meetings, including radiologists, dietitians and nurses. There was documentation in patients records if there had been an MDT meeting held.
Patients could see all the health professionals involved in their care at a one-stop clinic. The department had recently implemented one-stop clinics for urology. These had been very well received by patients. This meant the patient saw urology consultants, continence nurses and clinical nurse specialists all in one place, in urology.

Staff worked across health care disciplines and with other agencies when required to care for patients. Copies of clinic letters following patient’s appointments were sent to GPs to keep them informed of treatment plans and when patients had been discharged from services. The outpatient’s renal unit worked with many organisations and networks to provide patients with consistent renal care. The multi-professional kidney team that worked in the renal clinic involved doctors, nurses, dietitians, social workers and psychologists, they supported patients with community peritoneal and home dialysis and chronic kidney disease management.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

**Seven-day services**

**Some key services were available seven days a week to support timely patient care.**

Outpatient clinics were held at various times from 9am to approximately 5pm, Monday to Friday. Clinics in the outpatient department did not routinely provide a seven day a week service. However, some waiting list initiative clinics were held in the evenings and at weekends to reduce the number of patients waiting for an appointment. There were long-term plans to work towards seven-day services within outpatients.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support in patient areas. In all areas, we saw a range of health information and advice leaflets and posters.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle. The department supported the national priorities to improve the population’s health. Each patient who attended the department completed a healthy living form with the nurse. This included, alcohol, drug intake, smoking and weight patients. Patients were given relevant information and referrals to clinics, for example, smoking cessation and local weight loss groups.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had a good understanding of the need to assess patient’s capacity to make decisions when necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke with said they had been asked for their consent prior to interventions such as flexi-cystoscopies, venepuncture and prior to the insertion of intravenous lines. Patients told us they were given full explanations, together with the risks and benefits of the procedure. When alternative options were available these were discussed with them.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff explained that when patients were unable to give informed consent, they were supported to give their views and the patient’s relatives and carers were involved to provide further information about the patient’s wishes. There was multidisciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. Staff told us that all patients were given information leaflets before their clinic appointments with all the relevant information. If patients needed more time or wanted to discuss treatments further, this would take place before consent was taken.

Staff clearly recorded consent in the patients’ records. Most consent for outpatient appointments that did not require an invasive procedure was implied consent. We heard consultants explaining examinations to patients, and observed patients complying with requests to be examined, we did see consent routinely documented in the patients’ medical records when required.

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

**Lister Hospital**

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>26</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>26</td>
</tr>
</tbody>
</table>

In outpatient at Lister Hospital, the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in outpatients is shown below:
<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>3</td>
</tr>
</tbody>
</table>

In outpatients the target was met for both MCA/DOLS training modules for which medical staff were eligible.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. We asked to see the policy and staff could easily direct us to it and told us they frequently referred to it.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff speaking to patients with respect whilst seeking consent, taking observations and delivering care. Staff introduced themselves to patients and interacted respectfully and considerately.

Patients said staff treated them well and with kindness. We spoke to 12 patients (including their relatives) who described positive experiences of care. We observed a good rapport between patients, reception and nursing staff.

Staff followed policy to keep patient care and treatment confidential. Patient dignity and privacy was maintained during episodes of physical and intimate care, doors were closed at all times. Patients who required intimate examinations were offered the option of a chaperone.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We did not observe this interaction during the inspection, however staff could tell us of examples when this had occurred. Staff showed empathy and understanding for people and the way their anxiety and health affected their behaviour at times.
Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The service obtained patient feedback through the Friends and Family Test (FFT) which allowed patients to give feedback on their experience of the outpatients’ service and state whether they would recommend the service to others. For May and June 2019, 96% of patients using the service would recommend the service, compared to the England average of 93%.

We saw many complimentary FFT comments from patients. For example; “Excellent service and treatment in clinic”, “Brilliant service. Staff really nice” and, "All staff very friendly, work well as a team. Make you feel welcome and at ease”.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us that they felt that their emotional well-being was cared for. One patient said that the nursing staff were very patient with them during a consultation when they had been anxious. We saw that staff were kind and smiling during appointments, in order to reassure patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff were also aware of patients with complex needs and explained how they would support patients displaying difficult behaviours. We were given examples of when staff had recognised and supported the additional needs of patients with autism, by treating them in areas that were quieter.

Medical staff undertook training on breaking bad news. Nurses in the department did not receive any formal training, however, they were present in the room with the doctor for any additional emotional support required by the patient.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and carers.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. All the patients we spoke with were aware of the plans for their care and treatment. They said staff gave clear explanations and took time to answer their questions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw that consultants took time to introduce themselves to patients and asked them how they were feeling. We heard simple language being used to explain procedures and that the risks and benefits were explained, enabling patients to make informed decisions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed leaflets were available within the waiting areas, encouraging patients to provide feedback on their experience and how they could do this. There
were also additional experience surveys for specific specialties for patients to complete to provide feedback.

Staff supported patients to make informed decisions about their care. Patients were encouraged to ask questions and were repeatedly asked whether they had understood the information given to them. In appointments we also heard discussions about accessing other support for example community teams.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. For May 2019, the response rate for Lister outpatient’s department was better than the England average at 12.6% compared to the England average of 7%. For June 2019 the response rate was similar to the England average at 6.6% compared to the England average of 8.4%.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Outpatient clinics were provided at the Lister Hospital, Queen Elizabeth II, Hertford County Hospital and cancer services were at the Mount Vernon Cancer Centre. This meant patients could be seen closer to their home if the clinical specialty and capacity allowed. Patients could select where they were seen using the NHS referrals service.

The service provided clinics for 15 specialities including neurology, dermatology, rheumatology, urology and cardiology. To manage the high demand extra clinics were held at weekends to reduce waiting times for patients.

The urology speciality offered a ‘one-stop’ clinic, whereby a multidisciplinary team including doctors, specialist nurses and radiographers worked together in one area to ensure patients had their initial consultation, diagnostic tests, investigations and their follow-up consultation on the same day. This meant a more efficient service for patients, with fewer appointments needed, prompt diagnosis and in some instances, immediate treatment.

Facilities and premises were appropriate for the services being delivered. The department was clearly signposted, information provided prior to the appointment contained contact details of the booking service, a map of the hospital, directions, consultants name and information about tests. Car parking was available on the hospital site. Some patients’ we spoke with told us they never had problems finding a parking space, while others said parking was difficult. Everyone we spoke with had found a parking space on-site. Staff told us car parking fees was a common cause of complaint. There was information regarding public transport in the department and the main hospital reception. Patients who had a medical or clinical condition that prevented them from attending appointments were offered a patient transport service. We observed there was enough seating for patients and those accompanying them. There were adequate toilets within the department. Toilets suitable for disabled people and baby changing facilities were also provided.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. This was done through the mental health team based in the emergency department.
The service had systems to help care for patients in need of additional support or specialist intervention. Reception staff told us that they would inform patients if clinics were running late. Patients could leave a contact number and either to go to a coffee shop or for a walk, if there were clinic delays. Staff told us if a patient became distressed in the waiting area, they would try and take them into a consultation room as soon as possible in order to reduce their anxiety. Staff described situations when this approach had been required, for example with patients living with dementia, autism, learning disability or mental health conditions.

Managers monitored and took action to minimise missed appointments. Reminder texts were sent to patients who had provided their mobile phone details prior to the appointment. Since the roll out of this system there had been a reduction in missed appointments.

Managers ensured that patients who did not attend (DNA) appointments were contacted. All patients that did not arrive were contacted by the department and offered another appointment. If they did not attend on repeated appointments, they would be sent back to GP to be re-referred.

**Did not attend rate**

From February 2018 to January 2019:

The did not attend rate for Lister Hospital was slightly higher than the England average. Since January 2019 this had reduced after the commencement of text message reminders. The senior management team told us they were seeing a 3-4% reduction each month for patients that did not attend. Multiple DNAs would be sent back to GP to be re-referred following a clinical decision.

The chart below shows the did not attend rate over time.

**Proportion of patients who did not attend appointment, East and North Hertfordshire NHS Trust**

![Proportion of patients who did not attend appointment, East and North Hertfordshire NHS Trust](chart)

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients in these groups were highlighted on the electronic patient record system, which enabled the booking team to allocate earlier appointments. The department was able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe manner. There was a hoist available for patients who required help with mobility.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. We saw in most areas that a list of staff on duty was written on a clinic board, and in some areas, there were photographs of staff working in the department displayed. This helped patients to identify different types of staff and feel welcomed and treated as important partners in the delivery of their care. There was a learning disability champion within the department and a carers’ lead. They brought back information and knowledge to share with the rest of the team after meetings in that field.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. However, there were no hearing loop facilities within the outpatient department. The translation service was readily available for those who did not speak English as their first language.

The service had information leaflets available in languages spoken by the patients and local community. The service provided a range of paper-based information leaflets for patients within each speciality of outpatients. We found they were all current and relevant. Information was available in accessible formats.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients were provided with either face to face or a telephone-based translation service. Staff had a good understanding of how to access the service and in consultation rooms contact details for the interpreter service and a hands-free telephone to use for this service was available.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Referrals made by GPs came via paper off the electronic referral service and were referred directly into the specific referral assessment services (RAS). Appointments were then entered into the referral assessment service (RAS) by the contact centre staff, a consultant triaged the referrals daily and prioritise them.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. There were weekly access meetings to monitor performance. These were attended by the chief operating office and deputy operating office, the RTT performance manager, RTT cancer manager, and a quality and safety representative. At these meetings, the RTT position was discussed, as well as any remedial action plans required for specialties that were not performing against the national standard.

Each clinical speciality was responsible for their patient waiting lists and their RTT performance. This was managed by the individual directorate or specialty managers who were responsible for monitoring the patient tracking lists using data available on a trust wide electronic system. Each
Directorate produced patient tracking lists from the electronic system and shared this with clinical staff to promote discussions around managing patients’ timely access to treatment and identifying any capacity gaps.

Improvement plans were in place that clearly defined the process for both the 2 week and 18 week pathway, there were no delays at the time of our inspection entering the referral onto the system. Referrals were vetted and triaged by the specialty consultant and appointments were then booked according to priority.

There was a weekly escalation process for breaches of waiting times. After discussion, any issues with patients waiting longer than two weeks and 18 weeks (as appropriate to their clinical need,) were escalated to the access board.

The general manager for the clinical support service division had developed 15 key performance indicators, which had been approved by the directorate manager. They monitored items such as, short notice cancellations, did not attends, and patients waiting longer that 35 weeks.

Consultants used an electronic records system for recording details of patient’s appointments. Letters were dictated to their secretaries who typed them and scanned them into the system. Copies were printed and sent to patient’s GPs. In some circumstances the secretaries would not always type the letters and would be sent off to an external company to be typed.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From October 2018 to April 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways was generally similar to the England overall performance. The latest figures for April 2019, showed 86.7% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

The trust did not submit any RTT data to NHS England from September 2017 to September 2018. This was due to their new electronic record system not working effectively.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, East and North Hertfordshire NHS Trust.
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Seven specialties were above the England average for non-admitted pathways 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>99.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>97.1%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>93.4%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.6%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.8%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>88.5%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>87.9%</td>
<td>83.7%</td>
</tr>
</tbody>
</table>

Nine specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>90.6%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Other</td>
<td>85.2%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.5%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>81.7%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>81.6%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>74.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>69.2%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>68.0%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>67.3%</td>
<td>81.2%</td>
</tr>
</tbody>
</table>

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From October 2018 to April 2019 the trust’s referral to treatment time (RTT) for incomplete pathways was better than the England overall performance. The latest figures for April 2019, showed 88.1% of this group of patients were treated within 18 weeks versus the England average of 86.1%.

The trust did not submit any RTT data to NHS England from September 2017 to September 2018.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, East and North Hertfordshire NHS Trust.
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Twelve specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>100.0%</td>
<td>82.1%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>97.6%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>96.7%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>96.3%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.0%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>94.8%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>92.2%</td>
<td>83.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>92.1%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>87.2%</td>
<td>82.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>85.7%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>84.5%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

Six specialties were slightly below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic medicine</td>
<td>88.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>87.8%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>87.1%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>84.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.5%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Other</td>
<td>83.3%</td>
<td>89.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)
The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust’s performance has been above the national standard and the England average performance from July 2018 to March 2019. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), East and North Hertfordshire NHS Trust**

![Graph showing percentage of people seen by a specialist within 2 weeks of an urgent GP referral](image)

*(Source: NHS England – Cancer Waits)*

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust failed to meet the 96% operational standard and performed worse than the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all periods from April 2018 to March 2019. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), East and North Hertfordshire NHS Trust**

![Graph showing percentage of people waiting less than 31 days from diagnosis to first definitive treatment](image)

*(Source: NHS England – Cancer Waits)*

Managers worked to keep the number of cancelled appointments to a minimum. This was done through the text messaging service.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. This was a rare occurrence.
Staff supported patients when they were referred or transferred between services. When patients became unwell in the outpatient department staff supported them and arranged for their admission to the inpatient wards or transfer to another hospital when this was necessary. A decision flow chart was available to guide staff in the process.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Concerns or complaints leaflets and information about the Patient Advice and Liaison Service (PALS) were available throughout outpatients.

Staff understood the policy on complaints and knew how to handle them. Complaints were handled in line with the trust’s policy. Staff directed patients to contact the PALS if they were unable to deal with their concerns directly and advised them to make a formal complaint.

Staff in outpatients and the contact centre had received training on compassionate care, which had helped staff in how to communicate effectively with members of the public and patients who were unhappy or making a complaint. Staff spoke very highly of this training and said it gave them confidence in dealing with conflict and difficult situations.

Trust level

From April 2018 to March 2019, the trust received 333 complaints in relation to outpatients at the trust (34.4% of total complaints received by the trust). The trust took an average of 51.1 days to investigate and close complaints; this was not in line with their complaints policy, which states complaints should be completed within 35 working days. When we spoke with the senior management team at Lister, their updated data showed that 77% of all their complaints had been closed with 28 days and acknowledged within three days.

Managers investigated complaints and identified themes. Complaints were reviewed by the senior sister and the head of nursing; all complaints were answered fully with a full investigation.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>119</td>
<td>35.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>106</td>
<td>31.8%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>68</td>
<td>20.4%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>35</td>
<td>10.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Staff knew how to acknowledge complaints and patients received feedback from managers, after the investigation into their complaint. Where appropriate, early contact with complainants was made, in order to offer an apology and gain more information about the events surrounding the complaint. Staff told us they received very few complaints. Staff explained that they managed to resolve the concerns by means of a verbal apology, complaints investigation and a written response was not necessary.

Managers shared feedback from complaints with staff and learning was used to improve the service. Any complaints were discussed at monthly divisional governance meetings and learning from any complaints was discussed at staff team meetings.

**Number of compliments made to the trust**

From April 2018 to March 2019, there were three compliments about outpatients at the trust (6.4% of the total compliments received across the trust). Two of the compliments were received by audiology at Lister Hospital and one compliment was received by the breast clinic at the QEII Hospital.

The trust stated that compliments were received through the CEO office, these were responded and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust stated that they received multiple compliments through their social media platforms and also direct compliments to areas across the trust. The trust was currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

**Is the service well-led?**

**Leadership**

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The outpatients’ service was part of the clinical support services division, apart from trauma and orthopaedics and ophthalmology, which were part of the surgery division. There was a clear management structure and defined lines of responsibility and accountability. The divisional chair, divisional director and divisional head of nursing formed a triumvirate, which managed the division. The triumvirate had all completed a range of specialist leadership training and came from clinical backgrounds. The division was supported by general manager and had a non-executive lead for the division.

As outpatient clinics were not comprehensively in one division, there was ongoing combined work to manage the ongoing capacity and demand issues. Each speciality was responsible for its own management of demand and capacity and monitoring of referral to treatment time (RTT) targets.
The outpatient department was managed by an experienced senior sister, who worked closely with the head of nursing and the general manager.

We asked staff if senior leaders were visible and approachable and received a positive response. Staff told us that local leaders in their areas were always seen and were readily available to provide advice and support. Staff were fully aware of who the divisional leads were. There were posters with pictures and the titles of the divisional leads around the department. Staff did tell us that there was regular communication from the executive team on the intranet and through emails.

Vision and strategy

The service had a vision for what it wanted to achieve and aligned to the trust strategy. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a quality strategy for 2019 to 2024 aligned to the trust values. Outpatients did not have a specific strategy that they worked to but had a local plan aligned to; the overarching trust strategy.

Staff in the urology clinic showed evidence of aligning local plans to the wider trust strategy. They planned services to meet the needs of patients who used their services. We heard of many examples where these clinics had involved patients, carers and families to improve services. The one-stop clinic was an example of this.

There was high awareness of the trust’s PIVOT values for putting patients first, striving for excellence and continuous improvement, valuing everybody, being open and honest and working as a team. There was information about the trust strategy displayed within the outpatient department.

The vision of the department was to continuously improve the quality of services, in order to provide the best care and optimise health outcomes for each and every individual who accessed the services. Staff were aware of this.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We observed a culture of commitment, teamwork and support across all departments. All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the care they provided to people who used the service and were proud to work at the trust. One member of staff told us, “I look forward to work each day”. Another said, “I love working here. Great team, very supportive”.

Staff told us they felt well supported, valued and respected. Department managers and senior management teams promoted an ‘open-door’ culture and staff were encouraged to raise concerns and share ideas for service improvement. Managers told us they were extremely proud of their staff and the service they provided.
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 patients’ needs and providing safe care and treatment.

There were arrangements in place to promote the safety and wellbeing of staff. Staff could contact the trust’s security team for support and assistance if patients or visitors became verbally and/or physically abusive. Staff could access the trust’s occupational health and wellbeing team if they needed additional support at any time. Services they provided for staff included physiotherapy assessment and treatment and counselling, as well as information and support on healthy eating, getting active, stressbusting and smoking cessation.

The outpatients’ service celebrated staff success. Compliments received were shared with staff at safety huddles, team meetings, monthly newsletters and staff social media forums. Examples of compliments received were also displayed publicly on noticeboards.

There were mechanisms for providing staff with the development they needed. These included personal development reviews and appraisals.

Staff we spoke with understood the role of the Freedom to Speak Up Guardian (FTSUG) but no all staff could not name the FTSUG for the trust. However, they told us they would search the trust’s intranet for their contact details if they needed to raise any concerns with them.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Monthly governance meetings were held at directorate, divisional and trust wide level. These followed a standing agenda. The meeting minutes we reviewed confirmed governance matters, for example, incidents, risks, training compliance, staffing, mortality, audits, guidance, complaints and performance, were discussed. Minutes were detailed and contained copies of relevant reports and action plans. The monthly divisional board meetings fed into the accountability review meetings with the executive team.

The senior management team met every week, with all departments represented. This was an operational meeting to plan the week and discuss any upcoming issues that had or may present.

In addition to these meetings the division held weekly meetings considering improving financial delivery. A clinical workforce group and a clinical effectiveness meeting was held on alternate months.

The outpatient’s department had regular staff team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend these meetings, steps were taken to communicate key messages to them, which included e-mails and minutes of the meetings being available on the staff notice board.

Effective governance processes were established at departmental level. We were assured that emergency equipment, fridge and ambient temperatures where medicines were stored, and consumables were checked regularly. Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff were aware of how to complete incident reports and were encouraged to do so.
Clinics across all sites had twice weekly safety huddles in order for information from the various governance meetings to be shared with staff. Those who did not attend were able to read the safety huddle sheet.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had arrangements in place for identifying, recording and managing risks. Risk registers were held at divisional and trust wide level. The outpatient's department risks fed into the clinical support services divisional risk register. These were regularly reviewed at the local risk clinics supported by the risk manager and discussed at monthly divisional governance meetings.

One of the high risks for outpatients was the need for a more child friendly area within the waiting areas. Again, this was being considered. The head of nursing for paediatrics had been to the department to consider where improvements could be made for children and young people. Staff told us that the risks they were concerned about were accurately reflected on the risk register for their division. We saw that each risk had been approved for entry onto the register and had a rating, a named risk owner and a review date. We saw that the risks described, reflected the concerns discussed by staff throughout the service.

Clinical and non-clinical incidents were reviewed and discussed at the divisional governance meetings. This team were responsible for highlighting any trends or concerns about staffing, they reviewed incidents and policies. Minutes from meetings acknowledged the risks documented on the risk register and had actions in place to address them.

Performance review meetings were held for outpatient services monthly. A performance dashboard was produced to monitor the number of outpatient attendances, cancellations and patients who did not attend their appointment. We were told the leaders for outpatient services discussed successes and challenges at the meeting and provided feedback to staff at team meetings. There were meetings held three times a week to manage the two-week cancer wait.

The division presented a quarterly performance report for the trust finance and performance committee. This provided a summary of quality (incidents, risks, complaints and audits) performance, cancer targets with a recovery trajectory, finance, and workforce measures. It also identified key challenges and progress against the cancer strategy.

The trust had up-to-date policies in place to manage major incidents such as fire, bio-terrorism events or pandemic influenza. These were available on the trust’s intranet and also hard copies, should there be IT problems.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
Performance measures were reported and monitored. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements, where indicated. Performance targets were set in line with national targets where available. They had just implemented 15 key performance indicators (KPIs). Data was monitored, for example; short notice cancellations, did not attends, and patients waiting longer that 35 weeks. Each KPI had a detailed action and what metrics they would be measured against. These KPIs had only just been approved at the time of inspection, so we could not measure how they were doing against each one.

There were effective arrangements to ensure RTT performance data was accurate, valid and timely. This was an improvement from September 2018, when the electronic patient record system could not collate this data, to be submitted. Senior staff told us the trust’s ‘live’ RTT position was now very similar to the reported position, where previously they had large discrepancies. Data was submitted to external bodies, such as NHS England, as required.

The trust used numerous information technology (IT) systems to manage its activities. They had experienced problems with the electronic patient record system, this was highlighted on their risk register. No members of staff we spoke with voiced concerns about the trust’s IT systems during our inspection.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. There were arrangements in place to ensure confidentiality of patient information held electronically and we found staff were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

People’s views and experiences were gathered and acted on to shape and improve the services and culture. People who used outpatient services were encouraged to give feedback on the quality of service they received. The NHS Friends and Family Test (FFT) was used. For May 2019, the response rate for Lister outpatient’s department was better than the England average at 12.6% compared to the England average of 7%. For June 2019 the response rate was similar to the England average at 6.6% compared to the England average of 8.4%.

We saw FFT comment cards were available in all outpatient waiting areas and posters were displayed encouraging patients to leave feedback. Staff also monitored patient reviews posted on social media platforms.

There were posters displayed in the main areas of the department, showing, “you said”, “we did” information. An example from June 2019 was, ‘we want to be kept informed about waiting times in the clinics’, ‘we know display notices to indicate if there is a delay in appointment times and how long the wait is’.

Staff and patients were consulted on when developing the new one-stop urology clinic. Patients we spoke with spoke very highly of this service.

There was a trust newsletter which was distributed throughout the hospital to update staff on current issues and future plans. Staff told us they knew what had been included in recent newsletters. In addition, the chief executive circulated weekly emails to inform staff of topical...
information, new initiatives, service change, incidents, and learning from complaints. All staff knew about these emails were aware of them and found them informative.

From the conversations we had with staff and observations we made during our inspection, it was evident that staff were engaged in the service and empowered to help improve services.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The divisional leaders and ward leaders took action to make improvements in the running of the service. They had regular meetings where learning was discussed in a variety of forums. For example, matrons’ meetings and quality and governance meetings.

The service was committed to training and staff development. Most staff told us they were encouraged and supported to complete additional training.

Urology patients were offered a consultant led urology one stop diagnostic clinic. This was a new initiative ran by a team of urology specialists, who carried out assessments, fed back results from assessment and developed a care plan. Care plans were also shared with the patient’s GP for continuity of care.

The department liaised closely with the trust’s research team, there were a variety of research trials, for rheumatology and respiratory patients. The nurses were engaged with this and knew who to contact for patient recruitment.

In December 2018, the ophthalmology staff received a Purple Star award. This was awarded by the local county council and was given for the improvements the ophthalmology team had made to make sure the service they provide for patients with learning disabilities was adjusted to suit their needs.

The renal service offered a young adults transition service, this service aimed to improve the management of long term health conditions by empowering and educating patients and their carers by self-managing their condition.
### Medical care (including older people’s care)

#### Facts and data about this service

The medical care service at the trust provides care and treatment at Lister Hospital and the Mount Vernon Cancer Centre (MVCC).

MVCC is part of East and North Hertfordshire NHS Trust (ENHT) and provides a specialist non-surgical cancer service. The cancer centre operates out of facilities leased from a neighbouring trust, which causes some complications regarding estates and environment maintenance. The centre is 33 miles from ENHT’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 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.

The centre provides specialist non-surgical cancer services including:

- Inpatient ward.
- Radiotherapy service.
- Chemotherapy suite.
- Nuclear medicine imaging.
- Outpatient therapy service.
- A supportive care unit – providing cancer treatments and adjuncts, such as blood transfusions on a day care basis.
- Michael Sobell House (hospice) closed in December 2018 and now end of life care beds provided on inpatient ward.

There are 33 inpatient beds providing care for patients who require inpatient treatment because they are unwell during or following their radiotherapy or chemotherapy treatment. In addition, some patients are admitted for their treatment if it is particularly arduous, or the patient is frail. 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.

Following our last inspection in March 2018, the trust closed the on-site hospice to inpatients, Michael Sobell House, which provided end of life care for adults. The hospice contained an inpatient ward and a day centre. Inpatient services were transferred to Wards 10 and 11 at
MVCC, therefore the ward now provides end of life care for adults.

The cancer centre was previously inspected by the Care Quality Commission as a specialist stand-alone unit in March 2018. We inspected three core services, medical care, end of life care and chemotherapy. Medical care was rated as requires improvement, although effective and caring were rated as good.

During the inspection, we checked nine patients’ medical and nursing notes, and spoke with 16 members of staff, eight patients and four relatives.

### 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 did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.

Nursing staff were mostly up to date with all their mandatory training.

#### Mount Vernon Cancer Centre (MVCC)

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for registered nurses in the medicine department at MVCC is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>67</td>
<td>68</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>64</td>
<td>68</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>64</td>
<td>68</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>55</td>
<td>68</td>
<td>80.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The service set a target of 90% for completion of mandatory training. The 90% target was met for seven of the eight mandatory training modules for which registered nurses were eligible.

Nursing staff received training in Immediate Life Support (ILS) from another local NHS trust. The service provided us with training compliance levels following the inspection, demonstrating 100% of nurses had completed this training.

Sepsis training was provided to all nursing staff. Data provided to us following the inspection demonstrated 94% of nursing staff had completed this training as of 31 July 2019.

Mandatory training data for non-clinical support staff was provided to us following the inspection, demonstrating they were 94% compliant with mandatory training as of 31 July 2019.
Medical staff were not up to date with their mandatory training. Medical staff were significantly below the 90% trust target for information governance (75%) and equality, diversity and human rights (68.8%) training. A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in the medicine department at Mount Vernon Cancer Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td></td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td></td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td></td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td></td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>26</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>24</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>22</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for four of the seven mandatory training modules for which medical staff were eligible.

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

Medical staff received training in Immediate Life Support (ILS) from another local NHS trust. The service provided us with training compliance levels following the inspection, demonstrating 80% of medical staff had completed this training. This did not meet the service target of 90%. Managers told us there was an action plan in place to improve medical staff compliance with mandatory training, however we did not see evidence this was in place.

The service did not routinely provide sepsis training to medical staff. However, following the inspection, data provided to us showed the service was not meeting sepsis treatment targets. In response, the service told us they would request medical staff to complete sepsis training, with a view to achieving 90% compliance by October 2019.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to inpatient ward staff such as: conflict resolution, health and safety, moving and handling, infection prevention and control, equality and diversity, fire safety, information governance and sepsis training. Immediate life support (ILS) training was provided by another local NHS trust.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Training modules were not provided to staff as standalone training modules. Subject matters were incorporated into safeguarding adult and children training modules. However, we were not assured nursing and medical staff were confident in managing patients with mental health needs. Staff were unsure what support was available to a person experiencing mental ill health or who they could refer to. The service had link nurses who had attended additional training for dementia and for learning disabilities and they cascaded their knowledge to other staff.

Systems were in place for managers to monitor mandatory training, however they were not always effective in ensuring all staff completed it. It was unclear who had oversight of medical staff mandatory training compliance to ensure they were up to date. The matron and ward sister
monitored nursing staff compliance with mandatory training and prompted staff to book on refresher training. Staff training records we reviewed showed a list of training they had completed. Training due for renewal was amber colour coded. Staff accessed their training record online and checked to see when they were due to update their training. Staff were sent alerts three months before their training was due to expire to prompt them to book onto training.

Mandatory training for new staff was incorporated into the induction, and mandatory training compliance was reviewed as part of annual appraisals.

**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.

Both medical and nursing staff received training specific for their role on how to recognise and report abuse. During our previous inspection in March 2018, we found safeguarding training compliance for medical staff was 60%, below the trust target of 90%. During this inspection, we found significant improvements. Medical staff compliance with mandatory safeguarding training achieved the 90% target for both adults and children safeguarding levels one and two. Furthermore, nursing staff had exceeded the target across all safeguarding training modules. The inpatient matron was the safeguarding lead for the ward and had been trained to safeguarding children level two. This was not in line with the recommendations from the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

**Mount Vernon Cancer Centre**

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for registered nurses in the medicine department at the Mount Vernon Cancer Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>63</td>
<td>65</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>63</td>
<td>65</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all four safeguarding training modules for which registered nurses were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>30</td>
<td>32</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The 90% target was met for all four safeguarding training modules for which medical staff were eligible.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Admissions were planned and coordinated with the matron and consultants. The service used a recognised cancer treatment screening tool to triage some patients being admitted through the acute oncology service. This allowed staff to gather information to ensure patients' individual needs could be appropriately managed on the ward and post discharge. For example, the ward demonstrated measures put in place for a patient living with dementia. Staff arranged for a multi-agency case conference with the family to discuss their ongoing care. Staff also described how they utilised side rooms and requested additional staff for one to one care if a patient had specific care needs.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of the signs of abuse and told us they would report any concerns to the ward sister or matron. There were systems in place to highlight any safeguarding concerns. For example, safeguarding issues were discussed at handover, twice daily safety huddles and multi-disciplinary team meetings. We observed staff discussing the management of a patient, who potentially lacked capacity, during the daily safety huddle.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had not made any safeguarding referrals from July 2018 to June 2019. However, staff provided examples of when they would make a safeguarding referral if they were concerned a vulnerable patient was unable to protect themselves against significant harm or exploitation. Staff told us they would escalate any concerns to the ward sister and matron and complete an incident form.

The trust had a policy and procedure in place to safeguard children and vulnerable adults at risk of abuse which had been reviewed and was up to date. Policies were available to staff on the intranet and staff knew how to access them when required. Safeguarding procedures were clearly displayed at the nurse station on the wards. We saw adult safeguarding posters on display boards on the wards with local safeguarding team details and key internal contacts.

The ward had a safeguarding lead who reported to the head of nursing for cancer services. The trust board received information about safeguarding incidents, investigations and outcomes monthly.

Staff followed safe procedures for children visiting the ward. Patients under 18 years of age were not admitted to the ward for treatment. However, staff were aware of the requirement to ensure the safety of children visiting the service with relatives. Staff told us where possible, they utilised side rooms for patients who had children which we observed during the inspection.

Prevent awareness, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, was included as part of the safeguarding training. Female Genital Mutilation (FGM) was also included in level two safeguarding training, which all clinical staff completed. Staff were aware they had a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who had given birth to a female infant. Child Sex Exploitation (CSE) was included in level two and three safeguarding training. CSE is a form of child abuse and reportable to children’s social services in line with safeguarding procedures. Staff were aware of the potential indicators of abuse however, had not been required to raise a referral.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and generally well-maintained. All areas we inspected were visibly clean and generally tidy. Furniture was generally in good condition with no rips. Flooring and chairs were mostly wipe clean, however we did observe two chairs that were not wipe clean on the ward. The service completed monthly audits of the environment. We reviewed audits from January to June 2019. Audits demonstrated the service was on average 93% compliant across all measures. The audit measures included cleanliness of the environment (93%), cleanliness of patient equipment (95%), cleanliness of the sluice (92%) and waste disposal (93%). All patients we spoke with said the level of cleanliness and hygiene was of a good standard.

The service score for cleanliness was better than the England average. The patient led assessment of the care environment (PLACE) data for 2018 demonstrated Mount Vernon Cancer Centre (MVCC) scored 99.8% for cleanliness in 2018 which was above the England average.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We saw housekeeping staff completing various tasks throughout the course of the inspection. Records were in place to show housekeepers maintained a regular cleaning schedule. Fortnightly environmental and cleaning audits were completed by the estates department and the ward matron. Audits we reviewed, demonstrated a good level of compliance with the cleaning audit.

Clinical and nursing care equipment such as commodes, infusion pumps and mattresses were cleaned by nursing staff. A weekly schedule was in place and displayed at the nurses’ station. We saw cleaning was recorded on the weekly check sheet which was reviewed by the ward sister and matron.

Side rooms were available for patients who required isolation due to their clinical conditions. We saw there was appropriate signage to encourage staff and visitors to wear personal protective equipment (PPE). Side rooms had toilet facilities. Deep cleans were arranged following the discharge of patients with an infection and isolation rooms were cleaned before use. During the inspection, we observed isolation rooms being deep cleaned.

Staff mostly followed infection control principles including the use of PPE. Trust infection control guidelines were up-to-date, reflected national guidance and were available on the intranet. Nursing staff demonstrated a good understanding of infection prevention and control and most staff were up to date with mandatory infection, prevention and control training. Infection control was a standard agenda item on the monthly tea meeting agenda. Areas discussed were compliance with infection control practices including performance and audit outcomes.

Handwashing facilities and hand gel sanitisers were readily available. Lever operated taps were in place at most hand wash basins, with liquid soap dispensers and paper hand-towels nearby. This was in line with Health Building Note (HBN) 00-09. Hand washing posters were displayed above hand wash sinks and ‘Stop, hand sanitising’ posters were situated on the wards to prompt staff, patients and visitors to maintain effective hand hygiene to prevent the spread of infection.

Staff were compliant with their arms ‘bare below the elbow’ to enable effective hand washing and minimise the risk of contamination. PPE was easily accessible and used by staff, including protective aprons and gloves when undertaking clinical procedures. We observed staff washing their hands using correct hand hygiene techniques. For example, we observed staff completing regular hand washing practices between patients attending for chemotherapy. Staff used PPE
such as gloves and aprons and washed their hands before and after setting up and administering chemotherapy treatment.

Monthly hand hygiene audits were completed. We reviewed audits from January to June 2019. Audits demonstrated an average 89% compliance with hand hygiene audits, which is below expected compliance levels. In April and May 100% compliance was achieved, however in March 2019, the wards were 67% compliant. We reviewed ward meeting minutes dated 2 May 2019 which demonstrated managers discussed compliance levels with staff with a request for staff to adhere to the five points of hand hygiene. An infection control action plan was implemented in June 2019. One of the actions was to implement ward-based hand hygiene and infection control training by the infection, prevention and control team.

Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps (needles). Purple sharps bins were used to dispose of cytotoxic (cytotoxic drugs are used for cancer treatments to help prevent growth of cancer cells) waste. Bins were clearly marked and within safe fill limits. Date of opening of sharps bins were completed on all bins we observed.

Spill kits were readily available on wards which allowed staff to safely collect and dispose of bodily fluids including blood and urine. Specific spills kits were accessible to clean and dispose of cytotoxic waste and spillages. Staff were aware of the precautions when handling cytotoxic medications and waste.

The Control of Substances Hazardous to Health Regulations (COSHH) 2002, state employers need to either prevent or reduce their workers exposure to substances that are hazardous to their health. We observed and saw evidence of up to date COSHH risk assessments to support staff exposure to hazardous substances. We found most hazardous substances were kept in a locked cupboard within the dirty utility room. However, the room door was open and did not have a lock on it. During the inspection we identified a strong cleaning solution in a bottle that was not locked away.

There were no cases of hospital acquired MRSA reported. The national target for MRSA bacteraemia is zero and the trust reported zero cases since May 2018 to June 2019. The service reported zero cases of hospital acquired C. Difficile from May 2018 to June 2019.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found ‘I am clean’ stickers on equipment throughout the service. This enabled staff to instantly recognise when equipment was last cleaned. Whilst most dates were within 24 hours of the inspection, we identified some ‘I am clean’ stickers indicating the equipment had not been cleaned for over a week. For example, we found a hoist had not been cleaned since 30 June 2019 and an ECG machine had not been cleaned since 21 June 2019.

Environment and equipment

The service did not make sure the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients call bells were mostly in reach and staff generally responded quickly when called. Daily bedside safety checks were in place to ensure call bells were accessible to patients and working. During the inspection we observed call bells being accessible for most patients and answered quickly. Patients told us staff were quick to respond to call bells, however one patient told us staff were not as quick to respond during shift handover meetings.

The design of the environment did not always follow national guidance. Since our last inspection in March 2018, the ward had undergone some refurbishment to improve the quality and safety of the
environment. For example, the wards had a fire assessment completed and had undergone fire improvements including decompartmentalising of the ward to reduce the risk of fire spreading. Some of this work was yet to be completed in areas outside of the ward, however a plan was in place to complete this.

During our inspection, we observed there were enough side rooms for patients requiring isolation or patients undergoing palliative care. The service had sought charitable funds to refurbish two side rooms for younger patients aged between 18-24. We saw the rooms had been furnished with an in-built television, play station and with young person friendly colours and pictures on the wall. Side rooms all had toilet and bathroom facilities.

The communal bays had adequate space. Not all beds had piped oxygen, however there was sufficient access to portable oxygen cylinders. There was a nurses’ station situated in the bay to allow staff to observe patients who were unwell or at risk of falls.

The toilet and bathroom facilities were clean and generally well maintained; however, we were not assured all maintenance issues had been identified and resolved. For example, emergency and call bells did not work in the disabled access toilets. This was on the service risk register with a plan to mitigate the risks, however it was unclear when they would be back up and running. Mixer taps were not working in the male toilet and shower room, meaning patients could not access cold water to manage the temperature. This was identified by a patient and had not been risk assessed.

Storage space was limited throughout the wards. For example, there was limited space to store patient hoists. We saw one situated in the centre of the bay on ward 10. We also observed equipment storage rooms to be full of clinical equipment such as pump stands and chairs. We found store rooms were cluttered with excessive equipment.

Wards did not have a security access system to prevent unauthorised access or vulnerable patients wandering off the ward unattended. Whilst there was a nurse station/reception near the entrance to the ward, we observed this was not always staffed. During the inspection we also found areas of the ward unlocked and unattended as follows:

- The kitchen situated on the ward was not locked.
- The dirty utility room door did not have a lock on it. This room stored cleaning equipment and chemicals that could cause harm. During the inspection we found cleaning chemicals mostly locked away. However, we found strong cleaning solution stored unsecured in the sluice with the door fully open.
- Store rooms were unlocked, including a medical store room containing equipment such as needles and cannulation devises.

We were therefore not assured effective systems were in place to ensure the ward was secure and access was closely monitored.

Staff completed daily bedside equipment and safety checks. For example, staff checked there was oxygen available, emergency bells were accessible and working, call bells were accessible and working, there was adequate pillows and linen and the mattress was in good condition. This also included an assessment that the patient had the correct mattress for their needs. A checklist was attached to the patient bedside records and we saw each bed had a completed safety checklist.

Environmental audits were completed monthly. Audit measures included the clinical environment, patient equipment and furniture, storage and linen cupboards, dirty utility room and waste disposal. We reviewed audits from February to June 2019 which demonstrated an average 93% compliance with these audits.

However, during the inspection we found not all environmental risks had been identified and mitigated by the service as follows:
• We identified several ligature risks throughout the ward such as an unused chain attached to a partition in a bay. This was raised with managers who arranged for the chain to be removed the following day. Other ligature risks such as oxygen tubing and blinds were also identified, however there was not a risk assessment in place to mitigate these risks.
• Patient call bell points and emergency buttons were located high above patient beds and some staff could not reach them. There was a metal cane hanging from a bay divider which staff used to turn call bells off. This was in a throughway on the ward and could be used as a potential weapon or a hazard for people walking by. This was raised with managers and they moved it to the nurses’ station on the ward.
• We observed a broken glass pane on ward 10 that had not been identified by staff. This had a potential to cause harm to patients, staff or visitors if they were to lean on it. This was raised with managers and we saw the glass had been secured and we were assured by staff it had been escalated to be fixed.
• Two broken chairs were identified on ward 10 that were situated at the end of patient beds, used mainly for visitors. We raised this with managers and these were fixed during the inspection.
• Three adjustable bedside tables on ward 10 were not working correctly.

We were therefore not assured the service had robust systems in place to ensure all environmental risks and broken equipment was identified and fixed.

Staff carried out daily safety checks of specialist equipment. A resuscitation trolley with emergency equipment was available on the wards. A defibrillator, suction machine and portable oxygen cylinder was available. Equipment was checked daily and the resuscitation trolley was secured with tamper proof tags to alert staff if they had been accessed at any time.

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 most equipment.

The service had suitable facilities to meet the needs of patients’ families. The ward was separated into two wards; ward 10 male and ward 11 female. Each side had a day room where patients and their relatives could sit. A television was available with a large range of television channels. Managers told us they were in the process of applying for charitable funds to decorate the day rooms to make them a more comfortable environment. The service did have access to roll out beds for relatives to stay overnight with patients admitted for palliative and end of life care.

The service had enough suitable equipment to help them to safely care for patients. The service identified the equipment asset management system as a risk on the risk register. During our previous inspection, we identified medical equipment such as a blood pressure machines and an intravenous stand displayed do not use dates which had expired. Furthermore, a mobile x-ray unit stored on the ward also did not have an electrical testing label attached. During this inspection, we checked several medical equipment and patient care items and were assured they had been safety checked and electrical tested within appropriate timescales.

The service followed medicines and healthcare products regulatory agency (MHRA) guidance on the management of medical devices. Electrical medical equipment had registration labels and were maintained and serviced in accordance with manufacturer’s recommendations. All equipment checked had electrical safety testing labels attached showing they had been tested and were safe to use.

The service had recently recruited a service manager who was based on the ward and completed regular audits of equipment to ensure safety checks were completed within specified timescales. Staff told us they had noticed an improvement in timeliness of equipment being fixed and replaced since the last inspection.
Suitable equipment was available in line with the Royal College of Nursing (RCN) 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.

The ward did not store bariatric equipment for patients with a high body mass index. For example, there were no large size commodes for patients. However, staff told us bariatric equipment could be ordered prior to a patient being admitted.

Staff disposed of clinical waste safely. Staff followed guidance for the storage and disposal of waste. Healthcare waste posters provided staff with information about how to dispose of waste appropriately. These posters were displayed in several locations throughout the wards. 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. There were separate sharps bins for the disposal of cytotoxic waste and we observed these in use in treatment rooms. Cytotoxic drugs are used for cancer treatments to help prevent growth of cancer cells.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and acted upon patients at risk of deterioration. However, patients with suspected sepsis were not always treated within an hour. Observations of vital signs were not always completed on time and patients were not reviewed by a consultant within 14 hours of admission.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately, however observations were not always completed on time. The ward used the National Early Warning Score 2 (NEWS 2) to highlight deterioration in patients and guide staff in the process of escalation of a deteriorating patient. The service had recently implemented an electronic NEWS 2 system using smart phones. Staff inputted observations, including heart rate, respiratory rate, temperature, blood pressure and oxygen saturations. The system then calculated their NEWS score and guided staff when to complete the next observation based on the score. A patient who scored higher than 4 was escalated to the nurse in charge. A score of five and above, triggered an ‘amber’ alert call out to the emergency team.

Monthly nurse sensitive indicators (NSI) were completed by managers. We reviewed outcomes from these audits from April to June 2019. Audits demonstrated on average, 53% of observations were completed on time, against a target of 90%. Managers told us they monitored completion of observations and scores throughout the day. Managers identified system issues impacting on the audit outcomes. For example, since the ward took on end of life and palliative care patients following the closure of Michael Sobel House, staff could not adjust the observation software to remove patients who did not require observations. Staff told us this effected the overall compliance levels. During our inspection, we observed 100% of observations had been completed within timescales set for individual patients.

Staff told us the electronic system was much easier to use as it prompted them when observations were due and when to escalate. However, staff fed back that the information technology (IT) systems often failed, meaning they could not always use the electronic system to record observations. On these occasions, staff recorded the observations on a paper record.

The wards cared for patients undergoing cancer treatment, palliative care and end of life care. The ward did not have the facilitates to manage acutely unwell patients, however there was a system in place to support the early detection of the deteriorating patient. All new referrals were checked by the matron to ensure the patients’ needs could be met during the admission. The ward would not accept patients with a NEWS score of four or above to ensure all patients could be safely
managed. Upon admission, nurses completed a treatment escalation plan (TEP) which outlined interventions appropriate in the event of clinical deterioration. We reviewed nine records and each record had a TEP. Staff were able to articulate the process for escalation and dealing with deteriorating patients. During the inspection, we observed the procedure in practice. Nursing and medical staff worked well together to identify and treat a deteriorating patient.

Mount Vernon Cancer Centre (MVCC) did not have their own dedicated crash team. A crash team is a team of medical practitioners that stand by to resuscitate patients who have suffered cardiac or respiratory arrest. However, MVCC was located on a site, remote from the main trust building. The crash team was made up of an anaesthetist and medical registrar from the other on-site NHS trust. The duty matron, oncology registrar and junior doctor attended from MVCC. The crash team would attend all emergency calls and ‘amber’ calls. Staff told us it took approximately five minutes for crash teams to attend the ward. The inpatient wards procedure to handle a deteriorating patient was to stabilise them using equipment in the resuscitation trolley and then call 222. This call would trigger the crash team. The crash team then decided whether the patient needed to be transferred to a general hospital, at which point a paramedic would be requested by calling 999 to transfer the patient.

Mandatory training included basic life support (BLS) and intermediate life support (ILS). The service provided us with training compliance data showing 94% of nursing staff and 80% medical staff had completed the training. Medical staff were below the 90% expected compliance level.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. However, patients were not assessed by a consultant within 14 hours of admission. There was a nursing assessment proforma in place. This contained risk assessments and care planning tools based on nationally recognised assessment frameworks. Nursing staff were expected to complete them for patients on admission and repeated at regular intervals according to the patients’ clinical condition or the risk identified. We reviewed nine patient records and found risk assessments including Waterlow scores, which is used to determine a patient’s risk of developing pressure damage, and Malnutrition Universal Screening Tool (MUST) and other assessments such as falls risk assessments were all completed and reviewed appropriately.

During our previous inspection, we could not always find evidence in patients’ records of action taken as a result of falls risk assessments. During this inspection, we saw falls risk assessments were completed for all patients and where a risk was identified, a care plan was completed. We reviewed monthly documentation audits from July 2018 to July 2019. The audits demonstrated 99% of records checked had a completed falls risk assessment. However, we did not see evidence in records, that a lying and standing blood pressures had been completed. Where a patient was identified at risk of falls, we found there was a completed falls management plan. We reviewed monthly documentation audits from July 2018 to July 2019. The audits demonstrated 98% of patients identified at risk of falls had a falls care plan in place.

Patient falls were identified as a risk and monitored monthly by the service and displayed on their ward performance board. Three falls resulting in no harm were reported in June 2019 and six since April 2019 resulting in no harm. A review was completed of all falls incidents and an action plan was implemented in May 2019. We noted the following improvements:

- A nurse station had been placed in a bay on each ward where a staff member was always present. All patients deemed high risk of falls were placed in the bay for increased monitoring.
- Specific beds had been identified as high visibility beds where patients at risk of falls were prioritised.
- Pictorial signs were in place to identify patients at risk of falls.
- Physiotherapists’ were requested to assess all patients and support nursing staff in assessing their risk of falls.
MUST risk assessments were fully completed in eight out of nine records we reviewed. Those patients identified at risk of malnutrition had a fully completed nutrition care plan. We also saw evidence of nutrition and fluid balance charts being regularly updated to monitor intake. We reviewed monthly documentation audits from July 2018 to July 2019. The audits demonstrated an average 99% of records had a MUST risk assessment and 97% were reviewed within seven days. Documentation audits from July 2018 to July 2019 demonstrated of those patients at risk of malnutrition, 96% had a fully completed nutritional care plan and 97% were referred to a specialist dietician.

There were processes in place to assess and review risk of pressure ulcers and we found these to be completed in all nine records we reviewed. The assessment included a review of the skin condition, completion of a body map and an assessment of the correct use of equipment such as mattress requirements. SSKIN (Surface, Skin, Keep, Incontinence/moisture, Nutrition/hydration) assessment and care plans were for patients at risk of pressure ulcers, to document plans to prevent and treat pressure ulcers. Patients at risk of developing a pressure ulcer were provided with pressure relieving mattresses. We saw these were in place for patients who required them during the inspection. Monthly audits from July 2018 to July 2019, demonstrated 100% compliance with skin assessments.

Venous thrombosis-embolism (VTE) assessments were recorded on a patient medicine charts. We found VTE assessments were in place for eight out of ten medicine charts we reviewed. Where a risk was identified, appropriate medicines were prescribed. However, we did not see evidence of re-assessment. Medical staff told us the VTE would be reassessed if the risk changed. Furthermore, we saw evidence that pharmacists reviewed medicine charts and reminded doctors to complete the assessment.

There was a process in place to support cancer patients undergoing treatment, should there be any concerns during treatment and post discharge. Patients could call the acute oncology service and ward if they had any concerns with their treatment. We saw evidence of the United Kingdom Oncology Nursing Society (UKCON) triage assessment being used for patients who were admitted from the community. The triage was used by ward nursing staff and acute oncology nurses to assess the patients’ clinical needs and whether an admission was appropriate.

Patients were regularly reviewed by junior doctors on the ward, however we did not find evidence patients were reviewed by a consultant within 14 hours of arrival at the hospital, in line with London Quality Standards. We requested data to demonstrate the percentage of patients that were assessed within 14 hours of arrival, however this information was not routinely collected. The service provided us with an audit completed in April 2019 of a sample of patients demonstrating 0% of patients were reviewed by a consultant within 14 hours of arrival. Managers told us they had processes to mitigate and manage any risks. For example, all patients were discussed daily at multi-disciplinary team meeting (MDT). Patients not yet reviewed by a consultant were identified at these meetings and then seen by the junior doctors.

Managers told us a process had been implemented to improve this; however, it was not fully implemented at the time of the inspection. On-call consultants were asked to attend the site daily to complete a ward round, however this had not been fully embedded at the time of the inspection due to consultant availability. Senior managers were confident improvements had been made, however were unable to provide accurate data to demonstrate these improvements. We were therefore not assured the service had sufficient consultant availability to ensure patients were reviewed in line with national guidance.

Staff knew about and dealt with any specific risk issues. However, not all patients displaying symptoms of neutropenic sepsis received treatment within an hour. During our previous inspection in March 2018, we found 100% of patients with symptoms of neutropenic sepsis received treatment within an hour. However, during this inspection, we found the ward performance had significantly deteriorated. The service sent us a ‘door to needle’ audit completed from May 2018 to...
October 2018. The audit demonstrated an average of 65% of patients received intravenous (IV) treatment within an hour against a target of 100%. Furthermore, 21% received treatment within 1-2 hours, 8% within 2-3 hour and 6% above three hours.

This meant the processes to treat patients with suspected neutropenic sepsis were ineffective. Following the inspection, we requested an action plan to show how the service intended to improve compliance. The service told us they intended to increase their acute oncology service to 24 hour cover seven days a week to enable timely access to antibiotics. However, the action plan did not specify timescales, persons responsible and was unclear when the increase in provision of the acute oncology service would take effect. The service also intended to provide training to medical staff by a specialist sepsis team with an aim to achieve 90% compliance by October 2019.

Patients who had chemotherapy through an intravenous line, had regular monitoring of the intravenous (IV) site. Visual infusion phlebitis score (VIP) charts were completed for each relevant patient. VIP scores were used to monitor the sites of IV lines to check for signs of infusion phlebitis (inflammation of the vein the IV goes into).

The ward had a policy and procedure in place to safely manage patients who had developed extravasation. Extravasation is a term used when medicines that are being administered intravenously (such as chemotherapy) unintentionally leak into the surrounding tissue and cause damage. Staff had a good knowledge of the process, treatment, and the importance of recognising the early symptoms of extravasation. Staff told us they would normally transfer patients to a general hospital to be assessed by a plastic surgeon if required and to wash out the site. Staff reported these as incidents and we saw evidence where staff had effectively identified and transferred patients for treatment.

The service did not have 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff told us they would make a referral to a mental health trust if they had a concern about a patient, however were not able to articulate the pathway for supporting patients living with a mental health condition. Staff told us they rarely had patients with mental health conditions.

Staff could arrange for patients to undergo psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We were not assured there was a clear pathway from MVCC to local community mental health teams, however staff told us they could refer into local community services. Ward staff worked closely with the acute oncology service and clinical nurse specialists who were more involved with community-based services, therefore staff would also seek support from them. Staff said they could access one to one nurse care for patients at risk of self-harm or suicide. Staff told us they would utilise side rooms or high visibility bays depending on the level of risk.

The Lynda Jackson centre within MVCC was available to provide emotional support to patients and access to counselling. The Lynda Jackson centre had a timetable of activities that patients and their concerned others could access for support. For example, we saw a poster on the ward advertising art psychotherapy sessions on the ward and a singing group.

Staff shared key information to keep patients safe when handing over their care to others. There was a formal pathway for the 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 requiring urgent treatment, for example, bleeding, an emergency ambulance was called. Patients were transferred to an identified neighbouring trust for ongoing acute treatment. Staff used an urgent transfer book to document the details of events leading to transfers 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 patients care or nursing staff, followed up the patient through a daily telephone call. This ensured updates were recorded and monitored. During the inspection, we observed a patient being transferred due to a deterioration in their clinical
condition. The emergency medical team were present and emergency ambulance was called. A consultant was contacted by nursing staff to communicate concerns and details of the transfer and the receiving hospital was notified.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a handover between night and day staff and found it was structured and methodical. Staff discussed outstanding tasks, those patients requiring further review and those at risk of deterioration. This included information about patients’ high risk of falls, infection control risks and those with do not attempt resuscitation (DNACPR) orders in place. We noted staff identified patients with special support needs, for example, patients living with dementia and patients who were on time critical medicines.

A safety huddle took place following the handover where staff discussed staffing levels, skills mix, deteriorating patients and safeguarding concerns. The matron led twice daily safety huddles and ensured staff were clear about the risks and priorities for the shift.

**Nurse staffing**

The service did not have enough staff with the right qualifications, skills, training and experience. However, the ward had measures in place to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The annual inpatient ward vacancy rates were higher than the trust target for qualified nurses. The trust provided staffing data submitted before the inspection from April 2018 to March 2019.

**Mount Vernon Cancer Centre (MVCC)**

The table below shows a summary of the nursing staffing metrics in medicine at MVCC compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>119</td>
<td>5%</td>
<td>19%</td>
<td>4.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>70</td>
<td>12%</td>
<td>19%</td>
<td>4.8%</td>
<td>6,511</td>
<td>598</td>
<td>9,381</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

Nurse staffing rates within medicine at MVCC were analysed showing no indications of improvement. Since the data submission, vacancy rates for nursing and clinical support workers had increased from March 2019 to June 2019.

The service did not have enough nursing staff of all grades, however the service had processes in place to keep patients safe. At the time of the inspection, the service had significant vacancies, including two band six nurses, six band five nurses and five clinical support worker vacancies. Nurse sensitive indicators showed a sustained period of high vacancy rates for nursing staff. We reviewed the divisional board meeting minutes dated 16 May 2019 which stated that the ward could not accept any new admissions for two days in May due to the ward being understaffed. In June 2019, the vacancy rate was 42%. A strategic review of MVCC published in July 2019 raised concerns the service had a shortage of nursing staff and staff told us they were often short staffed.
on the ward. Managers told us these posts would all be filled in September 2019, following a recruitment campaign.

However, during our inspection, managers told us the ward had enough staff to manage the number and complexity of patients. The expected ratio of trained nurses to number of patients was one to six. During our inspection, we observed based on this ratio, there were enough trained staff, including the sister and matron, counted in the numbers to manage the number of patients. We observed the ward sister and matron supporting the ward clinically, both were very hands on and supportive of the team. Both staff and managers told us the sister and matron helped on the ward when they were short staffed.

We reviewed the nurse sensitive indicators between April and May 2019. This monitored the bed occupancy month by month which demonstrated the ward was considerably below the target bed occupancy. An average of 54% of beds (including palliative care and cancer treatment beds) were occupied during this period against an expected range of 90-95%. We requested additional information from the service which showed that from July 2018 to March 2019, the bed occupancy was on average 77% (based on 22 cancer treatment beds and excluding palliative beds). At the time of the inspection, there were between 20 to 22 patients on the ward with 33 beds available, therefore the ward was not running at capacity. Whilst the nurse vacancy rate was high, the number of patients was low. However, we were not assured the service could sustain this, if the bed occupancy increased.

Managers accurately calculated and reviewed the number and grade of nurses and support workers needed for each shift in accordance with national guidance. A staffing tool was used to calculate the number of nurses and clinical support workers required for each shift based on the acuity (level of care a patient requires) and needs of the patients. This meant appropriate skill mix and staffing levels were planned. The staffing tool was in line with NICE staffing guidance and the Royal College of Nursing safe staffing guidance. We observed daily hand overs and safety huddles. Staffing levels were discussed and monitored at these meetings to ensure there was enough staff on the ward.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing levels, skill mix and caseloads were planned and reviewed so patients received safe care and treatment, in line with relevant tools and guidance. The ward 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.

Staff told us where staffing was lower than expected due to sickness, the ward manager and matron would work clinically. Where the ward was not at capacity and acuity was low, the matron told us they would support other areas within MVCC. Managers told us this was an opportunity for staff to learn and develop skills in other departments.

The number of nurses and healthcare assistants on all shifts did not always match the planned numbers. Staffing levels were displayed on a whiteboard at the nurses’ station. However, it was unclear what the planned staffing levels were. Managers told us staffing numbers varied depending on the number and acuity of patients. During the inspection, we were aware a registered nurse was off sick, and 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.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The ward had stopped using agency staff, however did use bank staff to cover unfilled shifts due to vacancy and any sickness. The ward used regular bank staff due to the specialised nature of
the treatment and to promote continuity of care and minimise risk. Some bank staff were the wards existing staff covering additional shifts. New bank staff underwent a full orientation and induction to the ward.

**Bank and agency staff usage**

**Bank hours - qualified nurses, health visitors and midwives**

Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019. Bank hours had increased; however, agency hours had reduced.

**Agency hours - qualified nurses, health visitors and midwives**

Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives showed a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Processes were not in place to regularly review staffing levels and skill mix. Locum staff had a full induction.

The service did not have enough medical staff to keep patients safe. At the time of the inspection, the service was not fully staffed with junior doctors and consultants.

**Mount Vernon Cancer Centre (MVCC)**

The table below shows a summary of the medical staffing metrics in medicine at MVCC compared to the trust’s targets, where applicable:
### Medicine annual staffing metrics

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual locum hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>119</td>
<td>5%</td>
<td>19%</td>
<td>4.4%</td>
<td>1,980</td>
<td>2,393</td>
<td>1,127</td>
</tr>
<tr>
<td>Medical staff</td>
<td>21.1</td>
<td>20%</td>
<td>12%</td>
<td>0.1%</td>
<td>1,980</td>
<td>2,393</td>
<td>1,127</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and agency use.

The vacancy rate for medical staff was considerably higher than the trust target. Doctors told us they managed the vacancies well, but found it challenging when doctors had annual leave or were off sick. Where shifts were unfilled, staff told us they managed the tasks between them. Doctors told us they usually covered unfilled shifts themselves and the registrars sometimes work down to cover senior house officer (SHO) shifts when there were gaps in the on-call rota.

At the time of the inspection, there were four out of seven unfilled junior doctor vacancies. Managers told us they had recruited locum junior clinical fellows into three of these vacancies and intended to recruit into the fourth post. We were therefore not assured the service had oversight of medical cover or processes in place to plan for junior doctor medical rotations coming to an end. A strategic review of MVCC published in July 2019 found the service had a shortage of junior medical staff. Furthermore, the strategic review found the service did not have adequate consultant cover and recommended the recruitment of a second consultant to enable daily ward rounds to keep patients safe. Managers told us they intended to recruit a second consultant.

The medical staffing did not always match the planned number on all shifts. It was unclear what the planned number of doctors were expected on each shift. However, we were aware consultants were unable to attend the service daily at the time of the inspection to undertake ward rounds. Junior doctors also had to cover gaps in the rota, therefore we were not assured processes were in place to ensure medical cover was assessed and adequate.

Managers could access locums when they needed additional medical staff. During our previous inspection, we found the use of locum doctors was rare. However, during this inspection, we found there was an increasing use of locum doctors, including the oncology consultant in post. Senior managers told us they have a pool of oncology senior house officers who are registered, and block booked when required. Managers told us they do not book short term locums as they require specialist doctors due to the nature of treatment provided at Mount Vernon Cancer Centre (MVCC).

Managers made sure locums had a full induction to the service before they started work. Three locum doctors worked at MVCC at the time of the inspection with more due to start in August 2019. All three had undergone mandatory training and were just below the 90% compliance target. The service provided locum doctors with an induction booklet. We reviewed the booklet which was comprehensive and included information about working at MVCC such as training and key contacts.
The service did not always have a good skill mix of medical staff on each shift. Doctors on duty ranged from foundation doctors (FY1), newly qualified doctors) to specialist trainees, all of whom were attached to a team. Senior managers recognised the need to review medical staffing to ensure there was adequate resource to keep patients safe. The service intended to recruit a second consultant to improve the accessibility to specialist advice and support, ensure ward rounds were in place daily and patients were regularly reviewed. To mitigate any risk, the senior management team implemented a ‘tumour site’ consultant on-call system. The on-call tumour site consultant was expected to attend MVCC to complete a ward round daily whilst on call. This was a recent initiative and was not fully embedded at the time of the inspection.

**Staffing skill mix**

In February 2019, the proportion of consultant staff reported to be working at the trust across both Lister and MVCC, was higher than the England average, as was the proportion of junior (foundation year 1-2) staff. The trust was unable to provide us with data specifically for MVCC.

**Staffing skill mix for the 238 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>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>20%</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 - Medical (01/02/2019 - 28/02/2019)

The service always had a consultant on call during evenings and weekends. Consultants were not on site at the weekend, however doctors told us they were able to contact consultants for advice and support. Consultants were prepared to attend site if required.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we were not assured that discharge summaries were sent to GPs for all patients discharged.

Patient notes were comprehensive, and all staff could access them easily. Patient care records were generally written and managed in a way that kept people safe. The ward used paper records. We checked a total of nine patients’ medical and nursing notes. These records were mostly 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.
A nursing assessment proforma (NAP) had been recently implemented. These were fully completed in all nine records reviewed. The quality of patients’ care records was audited monthly by managers. We reviewed audit outcomes from July 2018 to July 2019. This demonstrated an average 100% compliance with record keeping measures.

Medical records were multi-disciplinary. Medical, nursing and therapy staff all documented care and treatment undertaken in the same records.

When patients transferred to a new team, there were no delays in staff accessing their records. However, not all GPs were sent discharge summaries to update them about their patients' hospital stay, treatment plan and medicines. Following the inspection, the service provided data showing only 76% of discharge summaries had been sent out to GPs from January to July 2019. Whilst there had been an improvement since January 2019, we were not assured the service had an effective process for ensuring discharge summaries were completed by doctors and sent out to GPs. Furthermore, of those discharge summaries that were sent to the GP, 46% were set within the 24-hour target. We were therefore not assured discharge summaries were sent to GPs, in a timely manner to ensure they had the most up to date information about the patients care, treatment and new or adjusted medicines.

There were processes in place when patients moved between wards, services and hospitals. This included referral, discharge and transfer documentation. Patient transfer checklists were in place for patients transferring between wards and departments. We saw all the information needed for their ongoing care was shared appropriately.

Records were not always stored securely. During the inspection, we observed patient medicine charts with patient information, left unattended in a public accessible area on two occasions. The first incident, there was one medicine record left on a table near the medicine trolley on the ward. The second incident, several medicines charts were left on top of the medicine trolley. We did however observe medical and nursing records being stored securely in lockable draws on both wards. Only authorised staff had access to the trolleys with a specially programmed key that was assigned to the person. Daily nursing notes were kept at patients’ bedsides, however for patients in side rooms these were kept on the wall outside of the room. We were not assured records for patients in side rooms were secure.

Notes for discharged patients and archived records were stored in locked cupboards in locked rooms.

Patient information boards were situated at the nurses’ station on both wards. These boards were used by medical and nursing staff as a visual of admitted patients and an overview of specific issues. The boards had flaps to protect information on the boards.

**Medicines**

**The service did not always use systems and processes to safely prescribe, administer, record and store medicines.**

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff had knowledge of safe medicines management and had access to the hospital medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines. However, we were not assured all staff were up to date with medicines management training. Following the inspection, the service provided medicine management training compliance information. Nursing staff on the ward were 66% compliant and medical staff 62% compliant. This was below the trust 90% training compliance target.
During the inspection we reviewed ten medicine charts. We found evidence that medicine charts were checked by pharmacists and they were generally clear and legible. However, we identified the following concerns:

- One medicine chart had five cancellations of medicines that had not been signed or dated by the person cancelling the medication. It was unclear why it had been cancelled and by whom.
- One medicine chart had a cross in the box. It was unclear whether the medicine was given or not as there was no number to indicate the reason for the omission of dose.
- Three out of ten medicine charts did not have the patients’ weight recorded.
- Two out of ten did not have a VTE assessment completed.
- One out of ten did not have an allergy status recorded.
- Oxygen was not prescribed in any of the medicine charts we reviewed. Furthermore, we reviewed a medicine chart of a patient being given oxygen. There was no evidence the oxygen was prescribed for this patient.
- One out of ten did not have medicines reconciliation.

During our inspection, we observed a medicine round. Nurses asked patients to confirm their name, checked their identity bracelet and the charts were signed to indicate medicines had been taken. We observed a nurse administering chemotherapy treatment. This medicine was counter signed by another nurse and we observed a three point identify check to ensure the right person received the right medication.

Furthermore, we reviewed medicine incidents from July 2018 to June 2019 and found errors in the administration of controlled drug (CD)s. Eleven CD incidents were reported. For example, a patient was given morphine sulphate rather than oxycodone and CD checks identifying possible errors in medicines given. Pharmacists told us they identified issues during their quarterly audits and fed this back to staff. Pharmacists advised us staff training had been initiated to improve medicine administration compliance. However, we were not assured staff were following effective processes for checking and counter signing medicines to ensure the correct medicine and dose was being given.

We were therefore not assured there were effective processes in place to ensure staff involved in the prescribing and administration of medicines were compliant with medicine management policy and procedures.

Oncology trained pharmacists were available and worked closely with medical and nursing staff on the ward and could be contacted if staff had concerns regarding medicines.

Allergies were mostly 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. Grab kits were available in treatment rooms for quick treatment of patients who had a reaction to chemotherapy or general allergic reactions. These kits were monitored weekly and overseen by the pharmacists.

Cytotoxic drugs used for chemotherapy treatment were stored and locked away in the fridge or medicine cupboard. Cytotoxic drugs are subject to safety restrictions issued by the Health and Safety Executive (HSE). We saw evidence nursing staff handling cytotoxic medications were trained in the management of cytotoxic exposure. All trained nursing staff had received chemotherapy and oncology training. New staff were undergoing a competency sign off.

Pharmacists were available to support staff in the management of cytotoxic medicine and there were appropriate spillage kits which staff had received training to use.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Medicine charts had been reviewed by the pharmacy team in all 10 records.
we looked at. All charts had medicines reconciliation completed and recorded. Medicine reconciliation is the process of creating the most accurate list possible of all medicines a patient is taking with the goal of providing correct medications.

Oncology pharmacists met with patients and relatives or carers to discuss their medicines post discharge. This included talking through the medicines prescribed, the side effects and what to do if they were concerned. Pharmacists provided details of the acute oncology service for patients to call should they have any concerns with their treatment.

Staff stored and managed all medicines in line with the providers policy, however prescribing documents were not always securely stored. During the inspection, we found medicines charts left out and unattended near the medicines trolley on two separate occasions. We also noted one of the wards top three medicines risks was lost medicine charts, therefore we were not assured the service had effective procedures to safeguard medicine charts on the ward.

Medicines were stored in locked cupboard in medicine rooms that were locked. Access to medicines was controlled by an electronic locking key system. Staff were assigned their own key, which granted them access for their shift. 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.

Medicine rooms were clean, tidy and medicines we checked were clearly labelled and in date. Medicine storage rooms had suitable preparation facilities for all types of medicines. For example, controlled drugs and antibiotics.

Staff used medicine trolleys for distributing medicines to patients on the ward. During the inspection, medicines trolleys were locked and when not in use were secured to the wall on the ward using a chain with a lock. This prevented it being moved by unauthorised persons. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Medicines that required refrigeration were kept at the correct temperature and staff checked and recorded the fridge temperatures daily. This ensured temperature sensitive medicines were stored correctly. We saw one fridge out of service following a spike in temperature. Staff followed the correct process by removing medicines and pharmacy staff reviewed and discarded medicines appropriately. However, we did not see evidence this was reported as an incident.

We saw all CDs were checked daily by two nurses in accordance with guidance. CDs are medicines such as morphine which are controlled under the misuse of drugs legislation. We reviewed the controlled drug registers and found there were no stock discrepancies. We saw the ordering and delivery systems for CDs met legal requirements. Registers were accurately maintained, and CDs were stored appropriately, with balances being regularly checked and recorded when administered.

Staff followed current national practice to check patients had the correct medicines. A pharmacist visited the ward every weekday and attended the daily multi-disciplinary team meeting (MDT). They provided support with prescribing and use of medicines and ensured there were appropriate stocks of medicines to make sure patients had access to them when they needed them. The pharmacy team provided an on-call service which guaranteed advice was always available. Nursing staff were aware of policies on administration of controlled drugs according to the Nursing and Midwifery Council (NMC) standards for medicine.

An electronic system was used to order chemotherapy medicines. The electronic system ensured chemotherapy was prescribed safely, and all the safety and diagnostic checks were completed. Doctors updated medicine charts of all chemotherapy ordered through the electronic system. Pharmacists worked closely with doctors and nursing staff to ensure all the information is correct before ordering.
Staff were aware that medicine related incidents should be reported, recorded and investigated. Staff we spoke with knew how to report incidents involving medicines.

Pharmacists completed several safety checks along with the ward sister and matron. These included a quarterly CD audit, drug chart audits and a weekly spot check. The spot check was completed by the pharmacist and included storage and documentation checks. For example, in June 2019, the check identified chemotherapy treatment stored along with take home medicines. Immediate actions were taken to communicate the issue with staff and change the storage system in the treatment room. There was an action plan in place with clear timescales and persons responsible to reduce the risk of this happening again.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Information about medicines incidents were displayed on a staff information board. Managers discussed incidents in ward meetings and safety huddles. For example, we reviewed ward meeting minutes in May and June 2019. There was evidence of discussion about the correct storage of chemotherapy medicines in the treatment room following an incident, demonstrating shared learning.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. In the records we reviewed we saw no patients who were having their behaviour controlled by medicines.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses, however, we were not assured that all incidents were reported. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Systems were in place for reporting incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff could identify and describe situations requiring completion of an incident form. Staff told us there was a good reporting culture and they were encouraged to report ‘near miss situations.

Staff reported some incidents that they should report, but not all. The trust used an electronic incident reporting system and staff we spoke with knew how to report incidents. Staff understood their responsibilities to raise concerns and report incidents. Staff could tell us about incidents they had reported. However, we were not assured staff reported all incidents. For example, we were not assured staffing shortages were reported as incidents. We reviewed divisional board meeting minutes on 15 May 2019 which noted the ward could not accept any new acute admissions due to staff sickness for two days in May 2019. We reviewed the service incident log, and this was not reported as an incident. Furthermore, we found the medicines fridge was not reported as an incident when it was taken out of use due to issues with the temperature.

Staff reported serious incidents clearly and in line with trust policy. However, there had been no serious incidents reported at Mount Vernon Cancer Centre (MVCC) in the 12 months prior to the inspection. Staff were able to describe the last serious incident and practice changes occurred just outside the 12 months prior to the inspection.
Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2018 to May 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Following the inspection, the service provided us with the number of incidents reported from July 2018 to June 2019. A total of 128 incidents were reported. The service demonstrated they thoroughly investigated incidents. Staff said they received feedback from incidents raised and felt this was informative. Actions to prevent incidents occurring again was identified and then shared. Staff were informed of changes to practice via incident feedback, safety huddles and were present on ward notice boards.

The service had no never events reported. 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 June 2018 to May 2019, the trust reported no incidents were classified as a never event for medicine at MVCC.

(Source: Strategic Executive Information System (STEIS))

Not all staff understood the duty of candour. 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. Whilst the service did not have any serious incidents in the 12 months prior to the inspection, they were open and transparent and gave patients and families a full explanation when things went wrong. For example, managers were able to describe how they applied duty of candour to the family of a patient who passed away. However, not all staff we spoke to understood duty of candour.

Managers debriefed and supported staff after any serious incident. Staff could access counselling should they need it and we observed debrief and discussion during a handover of a patient who had passed away.
Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw evidence of family being involved and updated on incident investigations. The service sent us copies of letters to families with updates on progress and offering them to make contact. Depending on the type of incident reported, the head of nursing, matron 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 investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received email notifications which contained incident feedback. Furthermore, staff told us they receive individual feedback if the incident related to them. We saw evidence in incident investigations of actions plans to feedback to specific staff and share learning wider.

Staff met to discuss the feedback and look at improvements to patient care. Staff had monthly meetings where they discussed incidents and the outcomes of investigations. We reviewed meeting in minutes from May 2019. There was evidence of discussion following a rise in falls incidents. The meeting minutes demonstrated discussion around placing patients at risk of falls in high visibility bays and ensuring falls documentation was completed. During the inspection, we saw changes to practice and the implementation of bay watch and high visibility bays. Furthermore, we saw evidence of learning from a previous serious incident where a patient had passed away. All staff we spoke to were able to tell us about the incident and lessons learnt. The incident had resulted in changes to practice in the management of patients who were being fed by a nasogastric tube. Meeting minutes demonstrated this was being closely monitored by managers and had been added to the service risk register.

There was evidence that changes had been made as a result of feedback. Staff demonstrated practice changes that had occurred following incidents. For example, a treatment escalation plan (TEP) had been implemented so staff knew what actions to take in the event of a patient deteriorating and at what stage a patient could no longer be safely managed at MVCC. These processes were fully embedded, and we saw evidence of them being enacted during the inspection.

Managers had systems to share learning with their staff about never events that happened elsewhere. During the inspection, we observed the matron updating staff in the safety huddle of incidents and learning from other sites. Whilst no never events were discussed we were assured the service had effective mechanisms to share learning.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

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

Data from the Patient Safety Thermometer showed the trust reported six new pressure ulcers, eight falls with harm and 10 new catheter acquired urinary tract infections from May 2018 to May 2019 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at East and North Hertfordshire NHS Trust**

1
Total Pressure ulcers (6)

2 Total Falls (8)

3 Total CUTIs (10)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Safety thermometer data was displayed on wards for staff and patients to see. Safety thermometer information was displayed on the ward notice board, so it was accessible to patients and visitors. The ward displayed information about performance in several areas such as medicines risks, infectious diseases, patient falls, new pressure ulcers, hand hygiene and ward cleanliness.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months. The ward had a good record of harm free care. The ward had not had any hospital acquired pressure ulcers or falls with harm in the 12 months prior to the inspection.

Staff used the safety thermometer data to further improve services. 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.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Patients were assessed, and a plan of care was put in place on admission. The service used a combination of national guidelines and policy to determine the care and treatment provided. This included guidance from the National Institute for Health and Care
Excellence (NICE), Royal College of Nursing policies, United Kingdom oncology nursing society (UKCONS) guidelines and Health and Safety Executive (HSE).

The service had up to date and evidence-based policies relating to cancer care. For example, the cytotoxic chemotherapy policy and management of extravasation of systemic anti-cancer therapy (SACT). The service also had detailed standard operating procedures (SOPs) for the checking and administration of SACT. Policies we reviewed referenced up to date relevant national guidelines and best practices. We observed staff following operating procedures by counter checking chemotherapy and saw specialist cytotoxic waste spill kits available in line with the service policy. There were regular audits to ensure compliance with policies, for example, the service had regular extravasation audits. Staff were aware of the policies and SOPs guiding their practice and received feedback following audits in safety huddles and ward meetings.

Staff told us they used a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. 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 and nutrition risk assessments and care plans. We also saw specific pathways in place such as a urinary catheter pathway and peripheral venous cannula care plans.

We saw evidence that managers including the ward sister and matron completed regular audits to assess practice against national and local guidance. For example, the service audited their practice and compliance with falls and nutrition guidance and infection prevention and control best practice. We saw evidence of shared learning following audits at team meetings.

The service also adopted the UKONS triage to screen patients admitted from the community. Acute oncology nurses supported patients in the community and during admission. Clinical nurse specialists (CNS) were utilised in some areas to ensure patients with complex needs were supported.

There was a wide range of information on best practice which was displayed in staff areas. This included information on hydration and fluid balance, safeguarding referrals and equality and diversity information.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff we spoke to were aware of the requirements.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a morning handover. Staff discussed how patients had been overnight, including their emotional wellbeing. We also observed an MDT, where medical staff discussed the psychological management and support needs of a patient. Patients were supported by clinical nurse specialists throughout their treatment, including their inpatient admission. Staff could also refer patients to the Lynda Jackson centre within MVCC. Patients could access information and support about all aspects of their cancer care and treatment, including emotional support. The service offered a timetable of activities for patients and carers including relaxation sessions.

**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.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were provided with water jugs, which were placed within reach. We observed staff and volunteers offering drinks to patients and relatives at regular intervals. We
observed, and patients reported that food and fluids were placed within reach. Procedures had been implemented to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds.

Protected meal times took place. This allowed patients to eat without being interrupted and meant staff were available to help where required. Patients told us the food was of good quality and they had plenty to eat and drink throughout the day.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Fluid balance charts were completed for patients whose hydration was an identified issue. Patient hydration was monitored during care rounds and recorded in patient notes. Food and fluid records, we reviewed were complete, accurate and current. We also saw evidence of mouthcare plans in place for patients who were unable to drink and eat through the mouth.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nursing teams used malnutrition universal screening tool (MUST) assessments. Patients were screened on admission for malnourishment and the dietitian assessed all patients whose nutritional needs were highlighted. Patients were weighed on admission and weekly thereafter to ensure nutritional needs were met.

Specialist support from staff such as dieticians and speech and language therapists (SALT) was available for patients who needed it. Dietitians and SALTs visited the ward to speak with patients on request. Patient records demonstrated patients were referred and seen by dietitians. Patients who had specialist feeding requirements were seen by dietitians a minimum of weekly. For example, patients who were unable to eat and drink and had a radiologically inserted gastrostomy (RIG) to enable food, fluid and medicines to be fed directly into the stomach, were seen weekly by the dietician. We saw evidence of nutritional advice, support and training given to patients and family to enable them to manage the device following discharge.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain, and generally gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients’ pain was well managed and routinely assessed and recorded. Patients undergoing specialist palliative care treatment were provided with medicines enabling them to continue their regular home medicines routine for pain relief.

Patients received pain relief soon after requesting it. Most patients we spoke with said staff responded quickly to requests for pain relief and generally all patients felt their pain was managed well whilst in hospital. However, one patient told us they waited 45 minutes for pain relief.

Staff prescribed, administered and recorded all pain relief accurately. Records demonstrated patients received pain relief. Medicine records indicated when patients could be given further pain relief as necessary. This meant patients could have additional pain relief when it was required. Patients told us they were given pain relief on request and were comfortable.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under relevant cancer accreditation schemes.**
The service participated in national clinical audits. The ward participated in the national patient safety thermometer scheme, which demonstrated the patient outcomes measured were in line with national averages. The service participated in the national lung cancer audit, however, the ward had limited control over outcomes. Managers told us this was because consultants did not manage the treatment pathway at Mount Vernon Cancer Centre (MVCC). However, the trust monitored lung cancer performance and implemented a trust wide action plan that fed into service performance reviews.

Mount Vernon Cancer Centre

Lung Cancer Audit

The table below summarises the trust’s performance in the 2017 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist</td>
<td>63.8%</td>
<td>Does not meet the audit aspirational standard</td>
<td>×</td>
</tr>
<tr>
<td>(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate</td>
<td>39.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery</td>
<td>15.3%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment</td>
<td>55.1%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy</td>
<td>69.2%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The service had a similar to expected risk of readmission for elective care than the England average.

Mount Vernon Cancer Centre

Elective Admissions - Mount Vernon Cancer Centre

From February 2018 to January 2019, patients at MVCC had a similar to expected risk of readmission for elective admissions when compared to the England average of 100.

- Patients in clinical oncology had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Patients in medical oncology had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Non-Elective Admissions - Mount Vernon Cancer Centre

From February 2018 to January 2019, patients at MVCC had a lower than expected risk of readmission for non-elective admissions when compared to the England average of 100.

- Patients in clinical oncology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Patients in medical oncology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Patients in clinical haematology had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

(Source: National Lung Cancer Audit)
(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))

Managers carried out a comprehensive audit programme of ward-based performance and quality measures. For example, this included monitoring of infection control practices, evidence-based nurse practice such as pressure and nutrition care. The wider service at MVCC participated in the national systemic anti-cancer therapy database (SACT) by providing data to NHS England with an aim to improve understanding treatment patterns and outcomes. SACT data and performance was discussed at divisional board meetings and the SACT quality improvement meeting.

Managers used information from the audits to improve care and treatment. For example, we saw a comprehensive national lung cancer audit action plan which detailed areas for improvements and planned actions with timescales and persons responsible. The action plan was regularly reviewed and updated with persons responsible. Updates were shared at divisional and programme board meetings.

Improvement was checked and monitored. The service completed regular audits and there was a regular system of spot checks to monitor improvements with quality and safety standards completed by the ward matron and sister. We saw action plans in place, for example there was an action plan to reduce the risk of falls following an increase in falls on the ward.

Managers shared and made sure staff understood information from the audits. We saw evidence managers provided staff with feedback from audits and spot checks at safety huddles and ward meetings. Furthermore, feedback was given to the wider multi-disciplinary team at daily meetings.

MVCC was accredited by the comparative health knowledge system (CHKS) following an assessment in June 2018. However, the service had not achieved any accreditations for its cancer services such as the Macmillan quality environment award (MQEM).

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance, however did not hold regular supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received training in tasks appropriate to their role. Most registered nurses had a specialist qualification and/or substantial experience in cancer care. All band five and six nurses who administered chemotherapy treatment on the ward were trained to do so and had completed oncology courses and regular updates. All new band five nurses were undergoing a competency assessment. Oncology pharmacists had completed chemotherapy competencies.

Following the closure of Michael Sobell Hospice, the ward took on ten palliative and end of life care beds. Staff told us they had training to develop understanding and skills in managing patients undergoing palliative and end of life care treatment. Some staff were trained in managing syringe drivers. Registered nurses were 80% compliant with syringe driver training. There was an action plan to improve compliance to 90% by September 2019.

Managers told us they had regular training sessions on the ward, where clinical nurse specialists facilitated workshops based on their specialities.

The service had monthly deteriorating patient simulation training sessions. This was facilitated by an anaesthetists and oncology consultant or specialist registrar. Nursing and medical staff were expected to attend to improve their skills and confidence in managing deteriorating patients. Staff we spoke to told us they completed the training and found it useful. Following the inspection, the
service provided training compliance levels demonstrating 72% of nursing staff and 50% of medical staff had completed the training. All new trained nurses, and medical staff were booked on the training sessions. The service intended to achieve 100% compliance by the end of October 2019.

Medical staff and clinical nurse specialists had access to advanced communications skills training to ensure they were able to break bad news sensitively. The trust reported 64% of consultants and 50% of clinical nurse specialists were trained in advanced communications skills; there had been a decrease in numbers due to an influx of new clinical nurse specialists and new consultants. However, they were able to access advanced communications skills training through the local hospice and the education lead was coordinating training for consultants and clinical nurse specialists. The service was also re-establishing a level two psychological skills course, facilitated by the in-house psychology team. This was mandatory for all the clinical nurse specialists and senior radiographers. Nursing staff within the inpatient service had undertaken some form of communications training and some of the registered nurses had undertaken advanced communication skills training.

Managers gave all new staff a full induction tailored to their role before they started work. Medical, nursing and pharmacy staff told us they had received a comprehensive trust and local induction. We spoke to new nursing staff on the ward who were undergoing a two-week supernumerary period. New nurses were undergoing oncology competencies through a nationally recognised programme and were supervised by band six nurses and the ward sister.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff confirmed they received an annual appraisal. Data provided to us before the inspection, showed nursing staff were compliant with appraisals and medical staff were just below compliance.

**Mount Vernon Cancer Centre**

From April 2018 to March 2019, 92% of staff within medicine at the Mount Vernon Cancer Centre received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>51</td>
<td>54</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81</strong></td>
<td><strong>88</strong></td>
<td><strong>92.0%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

Managers supported medical and nursing staff to develop, however there was not a formal process for clinical supervision of their work. Staff told us they had opportunities for informal supervision within their teams on a regular basis, however there was not a regular system of clinical supervision meetings, apart from the appraisal meeting. Whilst junior doctors did not have supervision sessions, they were invited to governance meetings to present findings of audits and share learning. Medical staff had opportunities to attend meetings to discuss complex case
management where learning was shared. However, having reviewed attendance lists at governance meetings, we did not see evidence of regular junior doctor attendance.

Clinical nurse specialists said they had access to supervision and some spoke about attending group supervision sessions. Junior medical staff were allocated clinical and educational supervisors. They told us they were encouraged to attend training courses and were given time to undertake them.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. The service held monthly ward meetings. Meeting minutes were produced and sent to staff to read if they could not attend the meeting. Subjects discussed within the meetings included recruitment, service and operational updates, governance issues including incidents and audits, equipment, new implementations being actioned and sharing of learning.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their training and development needs were discussed at their appraisal and there were opportunities to develop skills. However, some medical and nursing staff told us skill development was limited due to the ward not being able to manage complex patients requiring acute care and treatment.

The ward had recently introduced a nurse associate role. A nursing associate is designed to help bridge the gap between health and care assistants and registered nurses. They can be registered with the Nursing and Midwifery Council. Additionally, nursing associates can progress to become registered nurses.

Managers made sure staff received any specialist training for their role. 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.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us additional support was given to staff who needed more supervision in developing their skills to ensure standards had been achieved. 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.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were recruited safely and received initial training and continuing support. One volunteer we spoke to told us they underwent an induction before they started. Volunteers were visible on the wards, providing patients with refreshments. Volunteers also offered direction around the site to patients and visitors.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, patients were not reviewed by a consultant within nationally agreed timescales.**

Staff held regular and effective multidisciplinary meetings (MDTs) to discuss patients and improve their care. Effective MDT working practices were in place. Relevant staff, teams and services were involved in assessing, planning and delivering patient’s care and treatment. They worked together to understand and meet the range and complexity of patients’ needs. MDTs were held daily and
were well attended by the on-call consultant, junior doctors, nursing staff, pharmacists, cancer nurse specialists and therapy staff. We observed an MDT in progress. All ward-based patients were discussed including new patients and potential discharges. An overview was provided of each patient and staff gave updates, including the planned management of care and treatment. All attendees demonstrated good oversight of all patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Ward staff worked closely with the acute oncology service and clinical nurse specialists in co-ordinating hospital admissions and discharges. We saw evidence of effective MDT case meetings involving external organisations and family to discuss the safe discharge of a patient with complex needs.

Staff had good working relationships with teams at other local hospitals to support patients undergoing treatment and investigations off site. The named nurse would take responsibility for communicating with other clinical teams and this information would be shared with all staff at the daily MDT.

There were pathways for referral between specialities both at the hospital and local acute hospitals. 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. An emergency ambulance was called for patients who had a condition that required urgent treatment, for example, bleeding. Patients were transferred to an identified neighbouring trust for ongoing acute treatment. Staff were aware of these pathways.

Staff could refer patients for mental health assessments if they showed signs of mental ill health or depression. Staff told us they rarely had a need to refer to mental health services. Medical and nursing staff told us if they had a concern they would make a referral and discuss with the nurse in charge. However, not all staff were clear what the process was or who to contact.

Patients had their care pathways reviewed by the relevant consultants, however this was not within nationally agreed timescales. All patients admitted were under the care of a consultant and had their care and treatment reviewed during their inpatient stay. Whilst consultants were not always on site, there was effective communication between ward doctors and the specialist consultants. Due to consultant availability, patients were not all assessed by a consultant within 14 hours of arrival at hospital and ward rounds only occurred on a Monday and Thursday. An audit in May 2019, demonstrated 0% of patients were reviewed within 14 hours of arrival. Specialist registrars were on site to review care pathways daily and the junior doctors had regular contact with patients. However, we were not assured there was enough consultant cover to ensure timely reviews.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Consultant led daily ward rounds were not undertaken daily or at weekends. The lead consultant undertook wards rounds on a Monday and Thursday. The service was however in the process of implementing a daily weekday ward round. The service had requested on-call consultants to undertake daily ward rounds, however this had not been fully embedded at the time of the inspection. There were lead consultants on call seven days a week who could be contacted for advice and support.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Medical staff were highly visible on the wards and consultants were accessible when required. There were systems in place out of normal
working hours, so staff could seek support from medical staff and pharmacists. However, staff did not have on-site access to mental health support.

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. Diagnostic services were available Monday to Friday and on-call out of working hours. Services included imaging, emergency radiotherapy and laboratory facilities. Some services had to be accessed off site, such as procedures to insert drains or carry out biopsies under radiological or ultrasound control. However, as admissions were planned, most procedures required were not emergency and therefore were planned in normal working hours.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support. Patients were provided with information to help support them through cancer treatment pathway, manage their symptoms and promote their well-being. The Lynda Jackson Centre within MVCC provided relaxation sessions, complementary therapies, workshops and courses for patients. Some of these were focused on managing the side effects of treatments such as headwear workshops for people experiencing hair loss. Skin care and make up workshops could be accessed to boost confidence and wellbeing, whilst others were designed to help people move on when treatment had finished.

Health promotion information including leaflets regarding stopping smoking, living with dementia and advice on managing symptoms were available for patients and visitors to read.

Staff assessed each patients’ health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients underwent an assessment on admission, which included an assessment of their wellbeing and special needs. Patients also underwent a detailed assessment at the beginning of their treatment journey, receiving support from community-based nurse specialists, who supported them through their hospital stay.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.**

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. During our previous inspection, we found staff had limited understanding about their roles and responsibilities under the Mental Health Act (MCA)1983 and the Mental Capacity Act 2005. Staff were not confident in their abilities to carry out a mental capacity assessment. During this inspection we found improvements in staff understanding. They were able to articulate how they supported patients who lacked capacity. Nursing staff told us they would refer to the matron and medical staff should a mental capacity assessment be required.

Mental capacity and deprivation of liberty safeguards were discussed as part of the safety huddles. We observed a discussion about a patient where concerns were identified about their capacity. The team discussed completing a capacity assessment and actions taken to refer the patient for additional support.
Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke with said they had been asked for their consent prior to interventions such as chemotherapy, radiotherapy, brachytherapy and prior to the insertion of intravenous lines. They told us they were given full explanations, together with the risks and benefits. When alternative options were available these were discussed with them.

Two of the nine sets of notes we reviewed did contain a do not attempt cardio-pulmonary resuscitation (DNACPR) form. They were completed adequately; both patients had capacity and an MCA assessment was not required.

Staff clearly recorded consent in the patients’ records. All nine records we reviewed contained signed consent forms for various procedures. There were specific forms for different treatments. For example, a consent to chemotherapy form.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had a good understanding of the need to assess patients’ capacity to make decisions when necessary.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. During the inspection, we did not identify any patients who lacked capacity to make decisions about their care. However, staff explained when patients were unable to give informed consent, they were supported to give their views and the patients relatives and carers were involved to provide further information about their wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. We observed doctors providing patients with information about their treatment and we also observed nursing staff administering treatment. Staff explained what they were doing, and for example, what medication was for, how it would be administered and for how long. Staff asked patients if they understood and were happy to continue with the treatment.

Almost all nursing and medical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not provide standalone MCA and deprivation of liberty safeguards (DoLS) training. MCA and DoLS training were delivered as part of the adult safeguarding module.

**Mount Vernon Cancer Centre**

The trust set a target of 90% for completion of MCA and DoLS training.

A breakdown of compliance for MCA and DOLS training courses from April 2018 to March 2019 at the Mount Vernon Cancer Centre for registered nurses is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td></td>
<td>66</td>
<td>68</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td></td>
<td>63</td>
<td>65</td>
<td>96.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of compliance for MCA and DOLS training courses from April 2018 to March 2019 at MVCC for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL Page 316
| Safeguarding Adults Level 1 - 2 Years | 32 | 90.6% | 90% | Yes |
| Safeguarding Adults Level 2 - 2 Years | 32 | 90.6% | 90% | Yes |

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

The data demonstrates both nursing and medical staff were compliant with this mandatory training module.

### Is the service caring?

#### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions with patients and found staff generally had a good rapport with patients. Whilst delivering care and treatment, staff took time to talk to patients about how they were feeling and respond to any queries they had.

Patients said staff treated them well and with kindness. Every patient we spoke to, spoke highly of the care they were given on the ward. Patients told us staff were ‘very nice’ and ‘they take care of all the patients’. Another patient told us ‘staff are always friendly; staff talk to me and smile and laugh which for me is reassuring and comforting’. Patients described ‘brilliant care’, ‘staff are fantastic’, ‘care is 10 out of 10’. We saw plentiful cards, thanking staff for the care and treatment given during their hospital stay.

Staff followed policy to keep patient care and treatment confidential. Staff told us they could utilise meeting rooms and day rooms should they need to have sensitive conversations with patients. We observed curtains being drawn around patient beds by doctors when having conversations with patients and side room doors being closed. We observed privacy was always maintained when attending to patients care needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff demonstrated a good understanding of a patients’ individual needs. Staff described how they had supported a patient undergoing palliative and end of life care treatment who had cultural needs impacting on their care and treatment. Staff demonstrated compassion in supporting the patient and family with support from the hospital chaplaincy team. We saw minutes of a ward meeting demonstrating the compassion of staff who had organised a memorial service for the patient. Managers encouraged staff to attend.

The ward had a good relationship with the chaplaincy service who visited the ward to offer spiritual support to patients. Staff knew how to contact spiritual advisors to meet the needs of patients and relatives.

We observed ward handovers and MDT meetings. Staff displayed compassion and empathy when discussing patient care and this included discussions about the personal and social needs of patients. For example, we observed discussions about enabling a patient with children to have regular contact with them whilst in hospital.

#### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**
Staff gave patients and those close to them help, emotional support and advice when they needed it. Cancer nurse specialists were available for advice and support and staff could refer patients for additional support if necessary. The Lynda Jackson centre was onsite and provided emotional support and counselling to patients. The centre provided information about treatment, side effects, support groups and a range complimentary therapies including relaxation classes. The centre also provided 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.

One patient commented ‘I get emotional support from staff; everyone is helpful’.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Whilst the wards were busy, we observed a calm environment. Staff gave patients support where required. Staff told us they had implemented a high visibility bay, where a staff member was always present. Staff told us this enabled them to quickly respond to and support patients who may be experiencing distress. One patient told us they felt safer in hospital as staff were on hand to support them when they felt unwell and were anxious. Patients who were unwell or confused were given clear details of the time and place and offered reassurance of safety.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations skills. Most medical staff and 50% of clinical nurse specialists were trained in advanced communication. Patients told us staff were kind, respectful, caring and communicated clearly. Family were involved in the patients’ care and encouraged to attend case meetings. Cancer nurse specialists also supported patients when bad news was delivered. Patients described the support and communication from nurse specialists as ‘fantastic’.

Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. The chaplaincy service supported spiritual care across the services and ensured the delivery of spiritual, pastoral and religious care was adequate and appropriate in supporting patients who had received bad news.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed multi-disciplinary team (MDT) meetings where all staff involved in the patients’ care were present to discuss the treatment plan. This included discussions about emotional and social needs and wider family support needs. We observed staff being empathic, demonstrating a good understanding of their patients; all staff inputted into the care and treatment plan. Shift handovers included discussions about family support and social support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed nursing and medical staff talking to patients and their relatives about their care and treatment plan. Staff gave patients an opportunity to ask questions. Ward based pharmacists told us they sit with patients to explain their treatment, the purpose and side effects before a patient is discharged to ensure they understood, and the family understands.

Staff talked with patients, families and carers in a way they could understand. We observed nursing and medical staff talking to patients. For example, we observed a doctor talking about the next steps for treatment. The doctor spoke using plain English. We also saw evidence of diagrams...
being used to improve a patient understanding. A patient told us nursing and medical staff explained everything clearly and kept them informed about the treatment and progress.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed posters throughout the ward advertising how to provide feedback about care and treatment. Patients told us they knew how to feedback or make a complaint. The ward performance boards also provided feedback about the friends and family tests and displayed feedback given and responses to this. For example, we saw feedback suggesting having televisions would improve the patient experience. As a result, the ward installed multi-channel television in the day room.

Staff supported patients to make advanced decisions about their care. The MDT were available for patients to discuss options about their care and treatment. Patients had clinical nurse specialists who supported them through their cancer treatment journey to support the patient to make decisions about their care.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The Friends and Family Test response rate for medicine at the Mount Vernon Cancer Centre was 38.3% from April 2018 to March 2019. This was higher than the England average response rate of 24.2%.

The feedback from the Friends and Family Test was positive for all wards. A breakdown of response and recommendation rates by medical ward can be viewed below. The percentage of respondents who said they would recommend the ward to family or friends was 90% or higher for both medical wards for the 12 months overall.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 10</td>
<td>344</td>
<td>44%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward 11</td>
<td>139</td>
<td>35%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Key

- The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12-month period.
- Sorted by total response.
- The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

The ward displayed their friends and family tests outcomes on a performance board on the ward for staff, patients and visitors to see. The board was up to date with June data. This demonstrated 100% of the 19 patients who completed the test said they would recommend the service to their friends and family.

Is the service responsive?

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. The service did not always work well with others in the wider system and local organisations to plan care.
Managers did not plan and organise services, so they met the changing needs of the local population. The hospital 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. Due to the large catchment areas, meeting the needs of the local population was challenging for the service. The service had implemented service level agreements with local general hospitals to transfer patients, however it was unclear how managers considered and met the needs to the local population.

We were not assured the ward was able to open all beds for new admissions. Nurse sensitive indicators from May to June 2019, demonstrated an average 54% bed occupancy. Therefore, just over half of the 33 beds were utilised on the ward over this period. Following the inspection, the service told us that the low bed occupancy was due to the ward taking on ten additional beds following the closure of the on-site hospice. However, we requested further bed occupancy data and the service sent data for the whole ward and broken down to 22 cancer treatment beds. Data from July 2018 to March 2019, showed the cancer treatment bed occupancy was on average 77% against an expected range of 90-95%. Furthermore, we reviewed divisional board meeting minutes for June 2019 and there was a record the ward could not take new acute admissions due to lack of staff. We were therefore concerned the service was not sufficiently staffed to meet the needs of local people.

At our last inspection of Mount Vernon Cancer Centre (MVCC) inpatient services in 2018, issues were identified in relation to the planning of cancer services to meet the needs of the local population. Following a recent external review of cancer services at MVCC, managers were putting plans in place to progress with the recommendations. They had a draft action plan, with timescales for most actions to be completed by the end of August 2019. There was a steering group with a large membership including stakeholders such as the local clinical commissioning group, representatives from tertiary cancer centres and neighbouring trusts.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Managers told us they did not have any mixed sex breaches on the ward. There were two wards that operated as one, ward 10 accommodated male patients and 11 female patients.

Facilities and premises were not appropriate for the services being delivered to all patients. The inpatient ward accepted urgent and non-urgent referrals for patients to treat the symptoms caused by their cancer 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. However, the service did not have an acute medical service such as a high dependency provision or critical care. Patients requiring enhanced clinical support were transferred to a local general hospital for treatment to receive acute medical care. The service had implemented a process to early identify a deteriorating patient. The national early warning score (NEWS) threshold for identification and escalation of a deteriorating patient was lower than the recommended trigger point. Managers told us this was to ensure they could get the patient assessed and stabilised earlier and transferred to a district general hospital equipped to manage the acutely unwell patient.

During the inspection, we found patients were not always made aware there was an escalation and transfer procedure in place should their health deteriorate. We spoke to two patients who told us they were not aware of this. Some nursing and medical staff we spoke to told us they did not discuss this with patients. We were therefore not assured patients attending for treatment were fully aware there was a possibility of being transferred. Furthermore, we were not assured patients were aware the hospital was not equipped to deal with acutely unwell patients.

Processes were in place to reduce the number of patients being admitted where the hospital could not meet their needs. For example, as part of the referral process, patients underwent observations of their vital signs and general condition, to determine whether the ward could meet
their needs. Referrals were screened and the ward only accepted patients who scored a four or less on the National Early Warning Score (NEWS) prior to admission. Managers worked closely with the acute oncology service to ensure referrals for admission could be safely managed at MVCC.

Whilst the referral criteria and early identification process ensured patients could be safely managed on the ward, we were not assured the hospital was able to effectively meet the needs of local people undergoing cancer treatment.

Following our last inspection in March 2018, the onsite hospice closed, and the ward increased its bed capacity from 22 to 33 to accommodate patients undergoing palliative symptom control and end of life care treatment. The staff had undergone a period of transition and learning. We saw feedback from families and patients was positive about the care provided, however we were not assured the ward environment was a suitable and sustainable alternative to a hospice for patients undergoing end of life care treatment.

Staff had limited access to emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. However, there was no onsite provision for emergency mental health support. Managers told us emergency mental health support was accessed from the Lister Hospital, however, we were not assured all staff knew how to access it. During the inspection, we did not see evidence of mental health referral pathways to demonstrate how patients and staff could access this support if required.

The service had systems to help care for patients in need of additional support or specialist intervention. Managers told us they screened all referrals before admission. Managers took details about patients support and social needs including mental health needs. This enabled staff to assess whether the ward at MVCC could accommodate the needs of the patient before agreeing admission. It also enabled staff to put in place any additional support needs. For example, staff told us they had previously arranged for one to one nurse care or side rooms. During our inspection, we saw evidence of patients with specific needs being supported by staff. A patient with a young child was moved to a side room to enable the patient to care for their young child in a private space. A young patient was moved to a young person friendly side room to accommodate their personal needs.

The service relieved pressure on other departments when they could treat patients in a day. The MVCC departments worked well together to manage all patients. The ward was able to accommodate patients attending for day and ambulatory treatment.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Where possible, staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service screened all referrals before admission to ensure they could meet the needs of all patients referred and arrange for staff, resource and equipment to be put in place ready for an admission. Two health liaison team members were onsite to provide support to patients with a learning disability. They provided allocated time with patients attending the ward and stayed with them where necessary. Staff were also able to access one to one nurse care.

The ward had high visibility bays where a member of staff was always present to provide support to patients. Staff told us they utilised these bays for patients living with dementia and learning disabilities. Staff also told us they could utilise side rooms for patients who had carers with them.
throughout their stay, to provide more space and privacy, however this would be based on the needs of the patients.

Ward staff worked closely with the acute oncology service, specialist nurses and social care providers to ensure patients with complex needs were supported throughout their admission and their needs were met post discharge.

Pharmacists worked with families and carers to ensure they understood treatment regimens, side effects and were confident to manage these.

Wards were not designed to meet the needs of patients living with dementia. We did not see any evidence of environmental adaptations to orientate, reduce unnecessary cognitive stimulation or reinforce personal identity. Whilst both wards were tidy, storage space was limited, and items were stored on the ward which could be a potential hazard to a patient living with dementia. The two wards were joined, patients could walk between the wards which had the potential to cause confusion for patients living with dementia.

Doors to store cupboards were not locked and patients could easily walk in. For example, the dirty utility room door was open with a strong cleaning solution in a bottle which could be a potential hazard to a person living with dementia. The ward did not have secure access in and out which could pose a risk to a patient who wandered off the ward unattended.

Staff were aware of the ‘This is me’ documents and patient passports to support patients living with dementia and learning disabilities. During the inspection, we did not see any of these documents in place, however staff were aware of these booklets and how to use them with patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff said they were able to provide information in a range of different formats including large print if they were requested. MVCC had an accessibility team and information was available to explain the service and provide information in a variety of formats including, large print, braille, audio or sign language. Patients could contact the team for an assessment of their needs.

The service had information leaflets available in languages spoken by the patients and local community. The service provided us with examples of information leaflets in different languages such as Polish and Arabic, however these were not on display during the inspection.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpretation services. There was a poster on the wall at the nurses’ station with instructions on arranging interpreters. Language and communication difficulties were identified prior to admission so arrangements could be made ahead of the admission. During the inspection, we saw staff had arranged for an interpreter for a patient. Medical and nursing staff said they had not experienced any difficulties with accessing interpreters when they were needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients were provided with a menu to choose from that included a range of food. Patients told us the food was a good standard with a wide choice.

Staff had access to communication aids to help patients become partners in their care and treatment. 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. A hearing loop was fitted on the ward to improve the experience of patients who had difficulty hearing. Staff were able to access pictorial cards to help communicate with patients who may not be able to speak.
Access and flow

People could not always access the service when they needed it and receive the right care promptly. The service could not accept acutely unwell patients or those at risk of deterioration. Waiting times from referral to treatment and arrangements to admit and treat patients were not in line with national standards.

Managers did not monitor waiting times, however generally made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers told us they pre-booked patients in to start treatment and received emergency admissions through the acute oncology service, clinical nurse specialists and outpatients. Whilst the service did not monitor waiting times to be admitted for elective patients, managers told us they were rarely at bed capacity and beds were always available if required. However, divisional board meeting minutes from May 2019 stated that the ward could not accept referrals for two days in May 2019 due to staff sickness, therefore were not assured people could always access the service when they needed it.

Treatment for patients with the most urgent needs was prioritised. Electronic referral and booking systems were in place, which linked local hospitals directly to Mount Vernon Cancer Centre (MVCC). The service did not have a robust triage and referral procedure, however, managers told us they were in the process of developing a triage system.

The ward matron oversaw all referrals alongside consultants and the acute oncology service to ensure all referrals were safe and appropriate. The ward matron had implemented an acceptance threshold based on the patients’ clinical condition and results of observations. This ensured the ward could meet the clinical needs of the patient to avoid them being transferred to an acute setting during their admission.

Average length of stay

Managers and staff worked to make sure patients did not stay longer than they needed to.

Mount Vernon Cancer Centre

Elective Average Length of Stay - Mount Vernon Cancer Centre

![Graph showing Elective Average Length of Stay]

Note: Top three specialties for specific site based on count of activity.

- From February 2018 to January 2019, the average length of stay for medical elective patients at Mount Vernon Cancer Centre was 2.8 days. The England average was 5.9 days.
- The average length of stay for elective patients in clinical oncology was 2.6 days. The England average was 4.6 days.
- The average length of stay for elective patients in medical oncology was 3.3 days. The England average was 4.5 days.
- The average length of stay for elective patients in clinical haematology was 4.6 days. The England average was 10.8 days.

Non-Elective Average Length of Stay - Mount Vernon Cancer Centre
From February 2018 to January 2019, the average length of stay for medical non-elective patients was 2.7 days. The England average was 6.2 days.

The average length of stay for non-elective patients in clinical oncology was 2.8 days. The England average was 5.3 days.

The average length of stay for non-elective patients in medical oncology was 2.7 days. The England average was 5.2 days.

The average length of stay for non-elective patients in clinical haematology was 1.1 days. The England average was 6.3 days.

(Source: Hospital Episode Statistics)

This meant length of stay for patients who were admitted to MVCC was less for all patients than the England average.

The ward held daily multi-disciplinary meetings to discuss treatment progress. Meetings were well attended, and staff addressed any clinical and social issues impacting on patients’ hospital stay and discharge. Ward staff worked closely with the acute oncology service and clinical nurse specialists to ensure patients were suitable to continue treatment at home once the patients’ symptoms were manageable.

Referral to treatment (cancer wait times)

The percentage of patients waiting 31 days from diagnosis to first definitive treatment was just below the England average.

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust failed to meet the 96% operational standard and performed worse than the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all periods from April 2018 to March 2019. The performance over time is shown in the graph below, which demonstrates steady improvements since quarter two 2018/2019.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), East and North Hertfordshire NHS Trust
Following our inspection, the trust provided us with their most up to date information. The service achieved 96.7% compliance for the percentage of people waiting less than 31 days from diagnosis to first definitive treatment for admitted patients.

**The percentage of patients waiting over 62 days from urgent referral to first definitive treatment was above the England average.**

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust failed to meet the 85% operational standard and performed worse than the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, East and North Hertfordshire NHS Trust**

(Source: NHS England – Cancer Waits)

Following our inspection, the trust provided us with updated 62-day wait compliance data. The 62-day performance had increased to 75.4%. Whilst this was in breach of the 85% target, the service demonstrated improvements in performance.

The data above includes all treatment types for all types of cancer by quarter. Monthly data was also available from NHS England broken down by treatment type with different targets for different types of treatment. The trust told us their 31-day waiting time had been compliant for radiotherapy and chemotherapy in the 11 months prior to the inspection.
An action plan was in place to improve referral to treatment compliance for cancer treatment. Managers reviewed patient tracking lists weekly and addressed individual delays to treatment. The trust closely monitored urology which accounted for 45% of avoidable breaches. In relation to 62-day waits, action plans were in place for each tumour site. There was an improvement trajectory in place and each tumour site had actions to achieve milestones set.

Patient moving wards per admission

Patient ward moves were higher than the trust average. From April 2018 to March 2019, within medical wards at the MVCC, 88.4% of individuals did not move wards during their admission and 11.6% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patients moves were higher than the trust average at MVCC. Patients were moved to an acute district general hospital if their clinical condition deteriorated. Managers told us MVCC did not have the facilities to manage acutely unwell patients. The service moved patients who become acutely unwell, where the hospital could not safely manage their needs. The service had processes to early identify a deteriorating patient and request an emergency team to assess and treat the patient. If the patient did not improve, a transfer would be undertaken. Whilst the service had processes in place to respond to patient risk, we were not assured that MVCC could manage the needs of all patients admitted for cancer treatment. Furthermore, we were not assured the admission criteria in practice was reflective of the level of services the hospital could safely provide to all patients.

Staff did not move patients between wards at night. Data received from the service indicated there had not been any moves at night since January 2019. Prior to this, the service did not formally record night moves. Managers and staff confirmed they did not receive admissions overnight. Most admissions were pre-booked and urgent admissions were admitted in the day. Whilst the service did not report any night moves, staff told us the only time a patient would be moved at night would be if their condition deteriorated and required transfer to an acute hospital.

Managers and staff worked to make sure that they started discharge planning as early as possible. The nursing assessment proforma had a discharge planning section, however this was not completed in any of the nine records we reviewed. However, most patients we spoke to had a good understanding of how long they would be admitted for, based on their treatment regime and when they would be discharged. Discharge arrangements were discussed at daily staff handover and safety huddles. 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.

The wards had access to a range of allied health professionals to support the patient in hospital and plan for discharge. We observed physiotherapists and dietitians 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.

Daily multidisciplinary meetings were attended by medical staff, nursing staff, clinical nurse specialists, acute oncology service staff, Macmillan nurses, pharmacists and therapy staff. All patients were discussed and included discussions about their discharge. The team discussed blockages to discharge and any social care assessments required and therapies input.

Pharmacy services were provided Monday to Friday and included pharmacy assistant support. Medicines were available on discharge and in a format suitable for the patient. Pharmacists
attended MDT meetings and were proactive in arranging take home medicines for patients once discharge was agreed.

Managers did not monitor the number of delayed discharges. Whilst there was no formal monitoring in place, managers told us discharges were delayed at times due to discharge summaries not being completed and delays with take home medicines. Staff told us this was due to a shortage in junior doctors on the ward to complete the discharge summary. Following the inspection, managers told us they intended to put in place a reporting structure for delayed discharges.

GPs did not always receive discharge summaries. Data provided from the service from January to July 2019 demonstrated GPs were sent a discharge summary for 76% of patients discharged from MVCC. Furthermore, GPs should receive discharge summaries within 24 hours of discharge, in line with national standards. However, during this period, only 46% of discharge summaries were sent to the GP within 24 hours.

The service provided us with an outline of actions taken to improve this, however, we were not assured there was a robust action plan in place to achieve compliance with specific timescales, actions and persons responsible. The service had however recently recruited a service manager who was actively working with medical and administrative staff to improve the system and compliance levels.

Staff supported patients when they were referred or transferred between services. Clinical nurse specialists and the acute oncology service supported patients throughout their treatment journey.

Managers monitored patient transfers and followed national standards. Patients who transferred to other hospitals were monitored by nursing staff and the consultant. Some patients, once stable, would return to MVCC to continue their cancer treatment.

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

Patients, relatives and carers knew how to complain or raise concerns. All patients we spoke to were aware how to complain should they have any concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were posters displayed throughout both wards advertising to patients, relatives and carers how they could complain as well as share concerns and compliments.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke to were aware of the trust complaint policy and knew how to access it. Staff we spoke with were able to describe the complaints process and explain how they would advise patients to raise a complaint. Staff told us they worked with patients to resolve issues, however supported patients to make complaints should they not be satisfied with the response. Staff told us formal complaints were processed via Patient Advice and Liaison Service (PALS) who gave formal feedback on actions taken.

The service had not had any complaints in the 12 months prior to the inspection. However, there were systems in place to record, investigate and learn lessons from complaints. The service was provided with high level feedback from trust wide complaints and relevant learning.
Summary of complaints

Trust level

From April 2018 to March 2019, the trust received 188 complaints about medical care (19.4% of total complaints received by the trust). The trust took an average of 43.2 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 35 working days.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>89</td>
<td>47.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>37</td>
<td>19.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>33</td>
<td>17.6%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>17</td>
<td>9.0%</td>
</tr>
<tr>
<td>Facilities</td>
<td>5</td>
<td>2.7%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Integrated care (including delayed discharge due to absence of care package)</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From April 2018 to March 2019 there were no compliments about medicine at the trust.

The trust stated that compliments were received via the CEO office, these were responded to and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust was currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

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

Staff knew how to acknowledge complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. We also saw evidence of letters that had been sent to complainants to acknowledge their complaint. This was more than 12 months before the inspection. Whilst the ward had not received any complaints, managers recorded patient feedback on performance boards. For example, the ward received feedback a television would improve the experience for patients. The ward recorded this and the response, having put a television in the day room with access to a multi-channel television.
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The inpatient service at Mount Vernon Cancer Centre (MVCC) was managed within the cancer services division. The division had a divisional chair, a divisional director, head of nursing (HoN) and deputy head of nursing. The HoN was visible in clinical areas and the clinical director attended the site weekly.

The management structure of the inpatient ward had changed since our previous inspection in March 2018. Medical and nursing staff told us there had been significant changes in the leadership of the service and there was more of a senior management presence. Staff generally viewed the increase in senior leadership presence as positive, however some staff felt it was uncomfortable and anxiety provoking. There was some confusion among staff, including medical staff, about the roles of the divisional chair and the clinical director and the fact the clinical director was available at the trust for one day per week.

NHS England commissioned an external strategic review of cancer services, published in July 2019. The document identified that several reviews of cancer services at MVCC had been undertaken and had not resulted in substantial change. The review highlighted a lack of oversight and leadership of the services over a period and ability to influence other stakeholders, to benefit the development of services at MVCC. The report recommended that a full-time clinical director of oncology be based at the site and manage the transition to a new configuration of services. A senior manager we spoke with told us they had fulfilled this requirement with the appointment of a divisional clinical chair supported by a part time clinical director. The report also identified a need to increase consultant leadership to ensure daily ward rounds and patients reviews were in place.

During our inspection, we found there to be a clear management structure at local level; staff were aware of their divisional leaders and they were approachable. The lead consultant was a locum consultant at the time of the inspection and reported to the divisional chair. The clinical director advised us the post would be made substantive and they intended to recruit a second consultant to ensure the safe delivery of services. The matron had been recently appointed and reported to the head of nursing. The matron worked alongside four other matrons who worked within MVCC. They supported each other and had regular meetings, including attending daily bed meetings. The service locally was supported by a recently appointed service manager who worked closely with the matron and reported to the HoN.

Managers met with ward staff weekly to discuss updates, problems, staffing, training and sickness.

The ward sister managed the ward day to day and was managed by the in-patient matron. The ward sister was supported by the new matron and felt the new management structure was much more supportive. Registered and non-registered nursing staff reported to the ward sister. The ward sister often worked in the staffing establishments in times of staff shortages. Staff said they felt supported by their line managers and colleagues.

We met with the local management team during the inspection and found they were organised and demonstrated supportive leadership. For example, the service manager was based on the ward and had a good rapport with all staff. The service manager was proactive in supporting the ward with environmental issues impacting on clinical care. The clinical leaders were knowledgeable about the wards performance against the trust priorities and the areas for improvement and had embedded systems to improve staff morale and engagement.
The service supported managers in completing management programmes. For example, the ward sister was about to start a yearlong leadership programme. Furthermore, the trust provided shorter courses to support managers develop management skills.

All staff we spoke with were aware of the whistleblowing policy and many staff told us they would escalate concerns or challenge colleagues if patient safety was compromised.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, that was in the process of being developed with all relevant stakeholders. The vision and strategy was focused on sustainability of services and aligned to local plans within the wider health economy.

The trust had a quality strategy for 2019 to 2024 aligned to the trust values. Staff were aware of the trust values. There was information about the trust strategy displayed on notice boards and staff areas on the wards.

There was a Mount Vernon Cancer Centre (MVCC) clinical strategy for 2018 to 2022 with four key aims:

- To deliver high quality, safe, efficient and innovative services
- With partners transform how cancer care is provided
- Harness patient views and technology to transform the environment in which we deliver care
- Attract and retain high quality, expert staff supported by a culture to learn and thrive.

A clinical strategy delivery group monitored progress through an action plan to deliver these aims. MVCC produced strategic highlight reports for each strategic objective, reporting on progress, outstanding actions and actions moving forward. Inpatient managers met with the head of nursing monthly to provide overview of operational progress which fed into strategic highlight reports.

The external strategic review of cancer services at MVCC had resulted in recommendations which provided two preferred options for the future direction and configuration of services. The trust worked with key stakeholders to progress the recommendations of the strategic review and implement the preferred options. They had developed a draft action plan with key steps towards implementation of the recommendations.

Senior leaders communicated with staff at all levels to update them about key strategic issues. Senior leaders produced a monthly staff bulletin. We saw bulletins for June and July 2019 which demonstrated updates to staff on key issues and developments linked to the strategic objectives. We also saw evidence in monthly ward meetings the head of nursing attended them to talk about the trust strategy, MVCC clinical strategy and the findings from the strategic review. Some staff understood the purpose of the review and could describe the recommendations as well as the trust values. However, we were not assured all medical staff had a good understanding of the strategic objectives.

**Culture**

Staff we spoke to felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
Staff we spoke to told us they felt supported, respected and valued by management. Staff felt the new management structure was more supportive and they felt happier at work as a result. Staff were committed to providing the highest quality of care they could for patients and worked together to achieve this.

Managers worked clinically to support the nursing team when they were short staffed or when they needed support. Managers were passionate about providing a safe and high-quality environment for the patients and were visible on the ward, supporting staff.

All staff we spoke to were positive and passionate about working at MVCC and told us morale had improved recently. Staff were aware of the challenges of the estate and environment but were driven by the needs of patients using the service. Some staff felt their skill development was restricted due to the service not providing care and treatment for acute patients. However, staff felt they provided the best care possible and were supportive of strategic developments to improve the services provided at MVCC.

Staff felt action was taken to address behaviour and performance when necessary. Furthermore, the ward celebrated the achievements and hard work of staff. Staff nominated their colleagues by writing a comment and placing it on a board in the staff room to celebrate success and feedback from patients and relatives.

There was information displayed on the ward advising staff how to raise a concern. This suggested the trust had an ‘open culture’ in which staff could raise concerns without fear. All staff we asked understood the trust 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 service was open and transparent when things went wrong and fulfilled the requirements of the duty of candour. Documentation related to the investigation of incidents, showed patients were involved if they wished and the results of the investigation were communicated to them.

Staff we spoke with said they were treated equally and there was no exclusion to staff with protected characteristics. The trust had a workforce and race equality policy and had addressed any outstanding issues in an action plan, equality training was a mandatory training requirement.

On-call doctors had a rest room on the ward with a bed and bathroom. Staff told us it was not very well maintained and at the weekends, there were no facilities on site for them to buy food and drink. Senior managers told us they were in the process of obtaining charitable finds to refurbish the rest room for junior doctors on call.

**Governance**

Leaders operated effective governance processes, throughout the service, however it was unclear how the processes interacted. Staff at all levels were clear about their roles and accountabilities. However, not all staff were provided with regular opportunities to meet, discuss and learn from the performance of the service.

There were processes and systems of accountability to support the delivery of the strategy and services. 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 and reported to the trust governance group. The head of nursing, matron 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.
Weekly governance meetings rotated on a four weekly basis as follows:

- Divisional board meeting – head of departments and clinical leads were expected to attend.
- Audit and education meeting – a meeting to discuss service audits and was open to all staff. Staff were invited to present audit outcomes.
- Clinical governance oversight / Consultant meetings.
- Teaching session.

Whilst we saw a clear structure in place was set for the year ahead, we did not find evidence of membership of meetings and the expectation for staff to attend. We reviewed attendance lists for some of these meetings and found attendance was variable and often much lower than the numbers invited. For example, three out of 22 invitees attended the consultant meeting on 2 May 2019 and 18 out of 44 attended the consultant meeting on 6 June 2019. Furthermore, we reviewed the divisional meeting minutes in May, June and July 2019 and found it was unclear who attended these meetings and how the minutes were disseminated to staff who could not attend.

Mortality and morbidity meetings were undertaken monthly as part of the MVCC governance structure and the service was expected to feed into the trust wide mortality and morbidity meetings. However, we reviewed meeting minutes for December 2018, February 2019 and April 2019 and there was no representation from MVCC.

Minutes of governance meetings did not always demonstrate a robust approach to the discussion and management of key elements of the clinical governance agenda. For example, management of incidents and learning from incidents, themes from complaints and actions to reduce the risk of recurrence along with lessons learned, monitoring of compliance with NICE guidance or a planned clinical audit programme. However, the divisional board agenda had a standing agenda item for quality, safety, risk and patient experience, although this formed a small part of the agenda. Notes from the meetings stated themes from incidents and complaints were discussed but did not discuss learning and dissemination of learning.

Medical and nursing staff told us they rarely attended governance meetings as they did not have time. Medical staff told us they occasionally attended if they presented audits, however this was not very often. We were however assured ward meetings were well attended by nursing staff and there was high level engagement from the team at patient led multi-disciplinary team meetings.

The ward had monthly staff meetings which included discussions regarding incidents, complaints, bed occupancy, audits, workforce, sickness and education. We saw evidence lessons learnt were discussed at these meetings. Staff were able to tell us about specific quality and service improvements made following incidents. The inpatient matron attended divisional nursing meetings which discussed incidents, complaints, audits and other quality improvement initiatives and provided staff with updates.

### Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. The service had a risk register in place, however, the service did not always identify potential patient safety risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

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 37 risks on the Mount Vernon Cancer Centre (MVCC) division risk register, of which nine specifically related to the inpatient wards. Risks included management of the deteriorating patient, vacant junior doctor posts, lack of
IT systems access for new doctors, legionella detection and environmental issues. Each risk had a date added, a risk owner, a risk level and evidence of ongoing monitoring.

Risks were input on the electronic system by the governance team to ensure they had full oversight of them. Risks were owned by senior staff and the risks we reviewed were managed effectively. Risks were discussed and agreed at the divisional meetings before a risk was put on the register. Managers were able to tell us what was on the risk register, however most staff were not aware of the service risks.

However, during the inspection, we found a series of environmental and patient safety risks. We were not assured the risks had been identified by staff and mitigated against as follows:

- We identified a series of ligature risks on the ward, however, these had not been identified by staff. For example, we found an unused chain attached to a partition in a bay. We were concerned this had not been identified by staff as a potential risk to patient and staff safety. Following feedback, the service removed this, however there were other potential ligature risks not risk assessed. We found no evidence a ligature risk assessment had been completed to mitigate any potential risks to patients and staff on the wards.
- We were not assured there were comprehensive systems in place to check the safety of all equipment on the ward. A patient provided feedback of some health and safety issues that had not been identified. For example, there was a crack in a glass pane on the ward had not been made safe. This had the potential to cause harm to patients should it get worse or a staff or patient were to lean on it. A patient also identified broken chairs within the male side patient bay and broken bedside tables.
- Whilst there was a violence and aggression risk assessment in place, we were not assured the ward environment had been comprehensively assessed for potential risks. For example, we found a cane hanging on a bay partition. This was used by staff to reach the call bell points, to turn them off, for staff who were unable to reach them. This was in a public walkway and could be used as a weapon. This was escalated and removed, however, it was placed in another location in the bay, so we were not assured staff understood the risk.

Furthermore, we were not assured staffing risks were effectively identified and managed as follows:

- We found nurse staffing risks had not been added to the risk register. Data from June 2019 showed there was a 42% vacancy rate for nursing staff which was significantly higher than the trust average. We also identified the ward could not accept new admissions for two days in May 2019 due to there not being enough nursing staff. However, we did not see nurse staffing on the service risk register or any incidents being reported.
- Whilst vacant junior doctor posts were on the service risk register, we were not assured the service planned sufficiently to identify and mitigate these risks in advance. This risk was added to the risk register on 21 June 2019, identifying there were gaps in the medical cover rota due to four doctor posts becoming vacant in August 2019. The impact of this was risk to patient safety due to significantly reduced doctor cover and potential ward closure. Following the inspection, we requested an update on doctor vacancies. The service had recruited three locum associate doctors to start in August with one post still vacant. We were therefore not assured the leadership team has robust systems in place to ensure the service was staffed.
- There were concerns identified by managers that new doctors did not have access to several IT systems to allow them to view important patient information. This impacted on doctors being unable to do their job effectively. Nursing staff told us they provided access to doctors using their log in details, so they could view patient information. Whist this was on the risk register, we were concerned there was no immediate resolution to this issue. A comment on the risk register action log stated there was not enough resource to train...
doctors to use and access the systems. We were not assured the service was proactively managing this risk.

Performance review meetings were held monthly. The matron produced a monthly report for the head of nursing and this was used to report at the divisional board meeting. A performance dashboard was produced. The performance board monitored various areas relating to patient safety, for example, patient transfers, falls, hospital acquired pressure ulcers, incidents and complaints. Matrons also updated on successes and challenges at the meeting and provided feedback to staff at team meetings.

The division presented a quarterly performance report for the trust finance and performance committee. This provided a summary of quality (incidents, risks, complaints and audits) performance, cancer targets with a recovery trajectory, finance, and workforce measures. It also identified key challenges and progress against the cancer strategy. We did not see any evidence of reporting of other key indicators such as follow up to new rates or timeliness of clinics for example.

Information management

The service collected data and analysed data. However, staff could not always obtain reliable data in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated, although they were secure.

The service completed local audits as part of service performance measures and reported these to the trust board. For example, a monthly audit of patients transferred out was reported to the management team and was used to look for trends, themes and learning points. However, the service did not always have systems in place to easily review performance in specific areas. For example, the service did not routinely measure the percentage of patients reviewed by a consultant in 14 hours of arrival. The service sent through an outcome of an audit completed in April 2019, which demonstrated 0% patients were reviewed within 14 hours. Information sent through to us was unclear and the service did not have a system in place to report on those patients who had been admitted straight from outpatients and had been reviewed by the consultant.

Clinical staff and managers said there were challenges arising from poor IT systems and infrastructure. There were challenges for clinical staff in linking with other hospitals and in accessing the results of investigations. For example, they were unable to see radiological images from neighbouring hospitals and were unable to check blood results electronically. This impacted directly on patient care and created delays.

The service had recently implemented an electronic observations system. However, staff told us the IT system regularly went down, therefore staff had to revert to paper records.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff within MVCC recognised the importance of gathering the views of patients and actively sought feedback. The service used the friends and family test to assess patient experience and included follow up questions to explore how patients’ experience could be improved. We found Friends and Family Test (FFT) questionnaires and patient comment cards available in areas we visited. Staff displayed the results from the friends and family test in the department, along with
patient's comments. Patients feedback was mostly very positive; in relation to improvements, patients identified the temperature of the ward and access to televisions. In response to this feedback, staff identified steps they had taken to resolve the temperature issues and installed televisions into day rooms. 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.

The trust participated in the national cancer patient experience survey in 2017. From the results of the survey the trust had developed an action plan and provided a copy of this, which demonstrated the key issues for improvement were identified from the survey and action was being taken to improve. For example, possible side effects not being explained in an understandable way. There was a patient advisory panel for MVCC. Members of the panel were invited to contribute to patient information publications, evaluation of services and service improvement initiatives. The service was a member of the regional cancer alliance and a member of the East of England Local Cancer Network. The service engaged with them to reduce variations in pathways of care; reduce inequalities of access to all aspects of care and treatment and work across boundaries. The head of nursing also attended lead cancer nurse networks for the east of England and London.

The service worked with other local hospitals to improve referral pathways for deteriorating patients. Managers told us they often attended meetings at other sites to discuss the service level agreements and talk about the care they provide to improve working relationships.

Staff generally reported management communicated with them more now about service developments and key changes. However, staff did not feel they were given opportunities to be involved and contribute to service developments. The service had a staff engagement plan in place with actions to improve communications and career progression.

Learning, continuous improvement and innovation

The service demonstrated a commitment to learning, however, continuous learning and improvement processes were not fully embedded.

Since our previous inspection in March 2018, the service had made some improvements, for example, ward meetings were now recorded, and staff are more confident in understanding and applying the Mental Capacity Act.

The service also demonstrated learning from incidents and staff were able to demonstrate improvements to practice that had been implemented. For example, nasogastric feed care pathways and the urgent transfer and step up book. We also saw significant improvements made to the environment on the wards including refurbishment of younger person friendly rooms. Whilst we saw evidence of learning and continuous improvements, the service was restricted in their ability to improve the service due to the environment and lack of high dependency and critical care services on-site. We found areas that had not improved as follows:

- The daily consultant ward round was not yet embedded to ensure daily patient review by a consultant.
- The service did not record all incidents; therefore, we could not be assured that the service was learning from all incidents.
- Whilst steps had been taken to improve management of deteriorating patients, staff were limited in their opportunity to develop skills in managing more complex patients. Due to the restricted referral criteria, many patients could not benefit from the specialist ward for treatment and would have to be referred to a non-specialised district general.
The hospital had a research and clinical trials department. Staff within the hospital were involved in local, national and international research studies to develop new treatments and treatment pathways. For example, the service was leading within the UK on recruitment of patients for brain cancer trials. The ward occasionally undertook in-patient trials. The service were members of professional bodies and groups to further develop and improve standards of care. For example, a consultant was the clinical lead for development of NICE guidance for their specialty and a clinical nurse specialist had presented at international conferences for their specialty and sat on the committee of a national association of oncology nurses.
Outpatients

Facts and data about this service

The East and North Hertfordshire trust provide outpatient services at Lister hospital, Queen Elizabeth II (QEII) hospital, Hertford County hospital, community based clinics and the Mount Vernon Cancer Centre.

The outpatients team provide nursing and administration support to the outpatient clinics based at Lister, Queen Elizabeth II (QEII) and Hertford County Hospitals. The trust also supports some community-based clinics. In addition, Mount Vernon Cancer Centre (MVCC) supports an outpatient service for the cancer services provided on that site.

(Source: Routine Provider Information Request (RPIR) – Context acute)

Total number of first and follow up appointments compared to England

The trust had 611,317 first and follow up outpatient appointments from February 2018 to January 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and
the total for England, from February 2018 to January 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lister Hospital</td>
<td>520,587</td>
</tr>
<tr>
<td>Queen Elizabeth II Hospital</td>
<td>161,533</td>
</tr>
<tr>
<td>Hertford County Hospital</td>
<td>76,332</td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>75,291</td>
</tr>
<tr>
<td><em>East and North Hertfordshire NHS Trust</em></td>
<td>2,933</td>
</tr>
<tr>
<td>This trust</td>
<td>836,694</td>
</tr>
<tr>
<td>England</td>
<td>108,838,071</td>
</tr>
</tbody>
</table>

*Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from February 2018 to January 2019. The percentage of these appointments by type can be found in the chart below:

**Number of appointments at East and North Hertfordshire NHS Trust from February 2018 to January 2019 by site and type of appointment.**

![Chart showing percentage breakdown of type of outpatient appointments](image)

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

This evidence appendix relates to outpatient services at the Mount Vernon Cancer Centre (MVCC). The outpatient department have their own management team that reside within the cancer services division. At the time of the inspection the team at MVCC were managed separately from the outpatient teams from the other trust hospitals, but in conjunction with the other cancer services at the centre. As MVCC also provide inpatient medical care, chemotherapy and radiotherapy, there will inevitably be some areas of duplication between the evidence appendices for medical services, radiotherapy services and outpatient services at MVCC.

We inspected the service on 30 and 31 July 2019. We visited the all the outpatient clinics taking
place on those days in the outpatient department.
During the inspection, we spoke with 26 staff of various grades including nurses, pharmacists, consultants, junior doctors, clinical support workers, reception staff and volunteers. We spoke with eight patients, observed care and treatment and looked at 13 patients’ care records. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the service.
The service was last inspected in March 2016. At that inspection, it was rated good overall.

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 made sure everyone completed it.

Mandatory training completion rates

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

Staff received and kept up-to-date with their mandatory training. Information provided in the table below relates to nursing staff and shows trust targets for mandatory training were met. In addition we spoke with a range of other staff including clinical nurse specialists, pharmacy staff and reception staff who told us they were up to date with mandatory training.

Mount Vernon Cancer Centre

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at the Mount Vernon Cancer Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
At the Mount Vernon Cancer Centre outpatient department, the 90% target was met for all eight of the mandatory training modules for which qualified nursing staff were eligible. Care should be taken when interpreting these training completion rates due to a low number of qualified nursing staff in the core service. Only two nursing staff were identified as working within outpatient services at MVCC in the RPIR. When we enquired about this at the inspection, managers identified issues with the coding of staff in the electronic staff record and told us they had difficulties in obtaining collated information from the system. They agreed to provide data for the 10 whole time equivalent (WTE) nursing staff working within the service, both during the inspection and in response to a data request. This data was not received. However, managers and staff assured us that mandatory training was up to date for all nursing staff.

The trust did not report any medical staff working in outpatients at the Mount Vernon Cancer Centre. Medical staff working in clinics were accounted for within medical services within the trust and therefore training compliance was assessed within those core services.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included topics relevant to staff working in outpatient services.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff said mental health, learning disabilities, autism and dementia were included in training on the Mental Capacity Act (2005) and in adult safeguarding training. However, specific training modules on these topics were not mandatory. Six of the 10 nursing staff had completed dementia training and the trust reported that although learning disability training was not mandatory they recognised staff should be given the opportunity to attend this training. The training was due to be delivered it was expected staff in outpatient services to be fully compliant by the end of September 2019. The service had link nurses who had attended additional training for both dementia and learning disabilities and they had cascaded their knowledge to other staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The outpatient sister and matron told us they received notifications when mandatory training was due for their staff. Additionally a reminder was sent to individual staff. Managers told us they told us they looked ahead to identify when staff training was due and planned this into the e-roster.

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.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.
Nursing staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at the Mount Vernon Cancer Centre is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>10</td>
</tr>
</tbody>
</table>

At the Mount Vernon Cancer Centre outpatient department, the 90% target was met for all four safeguarding training modules for which registered nurses were eligible. Care should be taken when interpreting these training completion rates due to a low number of registered nurses nursing staff in the core service.

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

The trust did not report any medical staff working in outpatients at the Mount Vernon Cancer Centre. Medical staff working in clinics were accounted for within medical services within the trust and therefore training compliance was assessed within those core services.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware of the protected characteristics and the vulnerability of patients using the service. Staff regularly checked waiting areas to monitor the well-being of patients as they waited and to identify any issues that might need consideration or intervention, to maintain patients’ well-being.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to describe the signs of abuse and steps they would take if they identified a concern. The trust safeguarding team were available for advice and contact details were readily available in the clinic hub rooms.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained the process for making a safeguarding referral and they said they would involve the patient’s consultant and medical team, social services and other agencies as necessary. A specialist nurse gave an example of a concern they identified and the involvement of the social services team and police. They told us they had discussed the scenario afterwards during clinical supervision. Another nurse told us of a situation where a safeguarding referral was made and a multi-disciplinary team meeting was held to ensure the service took account of the issues within their care plan.

Staff followed safe procedures for children visiting the service /department. Patients under 18 years of age were not seen in the outpatient service at MVCC. However, staff were aware of the...
requirement to ensure the safety of children visiting the service with relatives. One of the examples discussed above, involved children of the patient and staff identified this.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The environment and facilities, although worn and in need of refurbishment appeared clean. Chairs and examination couches were made of fabrics that could be cleaned easily. Patients we spoke with who visited the service regularly, said they did not have any concerns about the cleanliness of the department. Domestic staff completed cleaning each evening and staff said they could obtain assistance during the day, if and when required. During the inspection, we observed domestic staff attended promptly when there were issues with one of the toilet facilities. Privacy curtains in the consulting rooms were disposable and those we checked had been replaced within the last six months, in line with recommendations.

The service score for cleanliness was better than the England average. The results from the Patient Led Assessment of the Care Environment (PLACE) audit for 2018 showed a rating of 99.9% for MVCC. The data provided by the trust did not specify whether the outpatient department was included in the audit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Internal audits of environmental cleanliness completed monthly by the trust, showed 100% compliance with the internal cleaning standards most months from April 2019 to July 2019; the exception being May 2019 when the score fell to 91%, but increased the following month.

Staff followed infection control principles including the use of personal protective equipment (PPE). Aprons and gloves were readily available in the consulting rooms and at intervals within the main outpatient areas. Staff were bare below the elbows and we observed staff adhering to good hand hygiene practices during the inspection. Patients said staff used the hand sanitising gel before carrying out any care or clinical examination. Hand hygiene audits were completed monthly and the results displayed in the department. We observed the results for May 2019 showed 91% compliance. Data provided by the trust showed an overall compliance of 93% from February 2019 to July 2019. We were told when any non-compliance was identified, the person would be spoken to at the time to ensure they were aware of the requirements. However, the trust did not provide an action plan to address issues identified in months when hand hygiene compliance fell below 95%.

Some patients had peripherally inserted central venous lines in place to allow administration of medication. They said staff used aseptic technique when inserting the line and when using the line. They told us the risk of infection was explained to them when the line was inserted and the need to maintain cleanliness was emphasised. The type of intravenous lines required for patients were not inserted in the outpatient department; they were inserted in a clean environment within the chemotherapy suite. Records were completed as required, with details about the equipment used and an insertion tool checklist and continuing care record form were completed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Nursing staff were clear about the equipment they were required to clean and used “I am clean” labels that showed equipment had been cleaned within the previous 24 hours.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

However, areas suitable for patients that were using wheelchairs, to wait, were limited and at times compromised access to emergency equipment.

Emergency call bells had recently been installed in most consulting rooms. The provision of call bells remained on the risk register for the service as there were four rooms where call bells were not installed. Manage said these had been ordered and would be fitted as soon as they arrived.

The design of the environment mostly followed national guidance. The outpatient reception area was not spacious and was cramped at times, when patients were waiting to register their arrival or make a follow up appointment. There was no clearly identified space for patients to stand when they were queueing, and although a sign indicated that patients should stand back from the desk to allow privacy of patients booking in, this was not always noticed by patients and adhered to. Staff told us they felt a movable barrier or ribbon could be used to indicate where patients should stand would be helpful, however, this had not been raised by staff with managers and actioned.

Reception staff said they could use a room in the private patients’ suite opposite the department if patients wished to have a confidential discussion, however, this was dependent on availability and there was no sign for patients to advise them they should ask if they wished to discuss something privately.

There was a central waiting area that was shared with radiotherapy patients. This had sufficient seating facilities; however, space for wheelchairs was limited. An additional waiting area was available for clinics in a separate wing of the department. This was small and access for wheelchairs was difficult. There was an alcove in this wing that was used to store the resuscitation trolley; however, there was seating in this area and it was the only easily accessible space for patients using a wheelchair. On three occasions during the inspection we saw this area being used and access to the resuscitation trolley was blocked. We asked staff to review the siting of the resuscitation trolley and/or the use of the waiting area, to enable swift access in an emergency.

The department had identified “hub rooms” for use by staff when reviewing patient’s records and for clinic administration. This ensured only items required during the consultation were taken into the consulting rooms and maximised the use of space. Consulting rooms where patients were seen individually were of adequate size and privacy curtains were in place to enclose the examination couches. Hand washing facilities were available in the rooms. The department was in need of refurbishment and flooring needed replacing in some areas, although steps had been taken to maintain safety through the use of tape to prevent trip hazards. The environment was identified on the service’s risk register. The building was old and the fabric was such that maintenance and alterations were difficult to undertake. Leaks in bad weather were frequent.

Staff carried out daily safety checks of specialist equipment. A resuscitation trolley with emergency equipment was available within each area of the department. Each trolley had a defibrillator, suction machine and portable oxygen cylinders. Equipment was checked daily and recorded and the resuscitation trolley were secured with tamper proof tags to alert staff if they had been accessed at any time.

The service had suitable facilities to meet the needs of patient’s families. There was space within the consulting rooms if a patient was accompanied by friend or relative.
The service had enough suitable equipment to help them to safely care for patients. Equipment such as vital signs monitors, weighing scales etc, were labelled to indicate they had been maintained in line with requirements and electrical safety checks had been completed. A separate room was available for staff to carry out wound dressings, take patient's bloods and other minor procedures. No invasive procedures were carried out in the department. Staff said they had sufficient equipment to meet patient's needs.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. A flow chart was displayed in the hub rooms for staff to refer to providing details of the procedure to follow if a patient became unwell in the department. Staff were familiar with the procedure and said they could arrange for transfer or the patients and admission if necessary. They were able to access the hospital resuscitation team if required. The trust also provided us with a copy of their policy which applied to both inpatients and outpatients for step up care and urgent transfer of patients to acute facilities. During the inspection we were aware of a patient's relative who fainted during a consultation. Staff responded quickly and efficiently to manage the situation and provide the appropriate care and attention.

Staff completed risk assessments for each patient on arrival. A registered nurse completed hourly rounding of patients waiting in the waiting room, speaking with them briefly and checking on their welfare. If a patient was feeling unwell, they took action to address this and ensure they were seen quickly as required. No invasive procedures were undertaken in the outpatient department.

Staff knew about and dealt with any specific risk issues. Many of the patients attended the outpatient department regularly and staff knew them and their medical history well. Some patients were in the process of receiving chemotherapy or radiotherapy and staff were sensitive to this and checked on their well-being. Staff had received training on sepsis and were alert to the possibility of this, which was a particular issue for those whose immune system was affected by the treatment they were receiving.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health) Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The Lynda Jackson centre within MVCC was available for patients to provide access to a psychologist and/or counselling if staff identified a need for additional support and expertise. They were also able to refer to the local trust mental health team if necessary.

Staff shared key information to keep patients safe when handing over their care to others. Outpatient clinics were multi-disciplinary and all members of the multi-disciplinary team handed over key details about the patients’ care and treatment to other members of the team. The hub rooms within the clinic were used for this and all the professionals involved in the clinic worked from the hub room and returned there between patients. Staff copied outpatient letters to other professionals involved in the care of patients to ensure key information was shared.
Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

However, staff and managers identified the need for additional clinical nurse specialists to improve patient access and provide optimal levels of care and support for patients.

The service had enough nursing staff of relevant grades to keep patients safe. However, there were fewer clinical nurse specialists than in other similar centres and this restricted the level of service they were able to offer. Nurses working within the outpatient service had experience and specialist training in the care of patients with cancer. The ratio of registered nurses to clinical support workers was higher than usual for outpatient services; however, patients attending the department were undergoing specialist care and treatment programmes and had complex needs. Nurses were able to provide the specialist input patients required and ensure their safety was maintained. This, to some extent, mitigated the impact of lower than average numbers of clinical nurse specialists within the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers said a recent staffing review had been undertaken for the outpatient service and this indicated there were sufficient nursing staff to provide support at the clinics. They also identified a greater than average ratio of registered nurses. There were plans in place for the extension of opening hours of the service and this also impacted on the staffing required. In addition, the number of patients attending for wound dressings and blood tests in the procedures room had increased. Managers felt that some of these could be provided in other location within MVCC to relieve pressure on staff and on the outpatient capacity issues.

Managers said they had also undertaken a review of specialist nurses and benchmarked the numbers of specialist nurses against two other cancer centres. A requirement to expand the number of clinical nurse specialists was identified and managers said they were exploring sources of funding to enable them to provide additional clinical nurse specialists in each specialism. The number of breast care specialist nurses had recently been increased and additional hours for the lung care specialist nurse provision had also been agreed.

The manager could adjust staffing levels daily according to the needs of patients. Senior nurses said they flexed the number of staff on duty according to the number of clinics. Managers utilised bank and staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

The number of nurses and healthcare assistants on all shifts matched the planned numbers.

Mount Vernon Cancer Centre staffing data

The data provided by the trust in their provider information request (PIR) was inconsistent in relation to staff identified as working within outpatient services at MVCC in different patients of the PIR. Therefore, the data provided in this section may include staff who were not considered to be within the current staffing establishment for the service and should be treated with caution. In addition to the information provided in the tables below, we reviewed staffing establishments with the senior nursing team to provide a more accurate picture and the information we obtained is provided in the text below each table/graph.

The table below shows a summary of the nursing staffing metrics in services for outpatients at the
Mount Vernon Cancer Centre compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>14</td>
<td>47%</td>
<td>0%</td>
<td>5.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>9</td>
<td>50%</td>
<td>0%</td>
<td>0.4%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The trust used a traffic light system (red, amber, green) to monitor staffing levels, where red indicated unsafe levels, amber when planned levels were not achieved but the area was considered to be safe and green when planned staffing levels were achieved. Monthly data provided by the trust indicated there were no red shifts from April 2018 to March 2019 and between 97% and 100% of shifts were rated as green in the same period.

The trust told us they used bank staff to cover sickness absence, or mitigated the risk internally. They did not use agency staff.

Nurse staffing rates within this core service at the Mount Vernon Cancer Centre were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates turnover and sickness.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

**Vacancy rates**

The service had low vacancy rates.

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives were not stable and may be subject to ongoing change.
Managers were not able to explain the high vacancy rates derived from the provider information return and we concluded this was probably due to changes in the allocation of staff within the electronic staff record. A manager said some staff had reduced their hours in the middle of 2018 and these hours had been replaced, however, this did not give a 60% vacancy rate.

Managers told us their current nursing establishment for outpatient services was 10 WTE. This comprised a band six nurse, four band five nurses, two band three clinical support workers and three band two clinical support workers. There was one whole time equivalent vacancy.

Medical staffing

Mount Vernon Cancer Centre

The trust did not report any medical staff working in outpatients at the Mount Vernon Cancer Centre. Medical staff working in clinics were accounted for within medical services within the trust.

Consultants and registrars attended the service to see patients in outpatient clinics and were supported by clinical nurse specialists who also ran nurse led clinics. Registrars told us they were well supported by consultants and the hub arrangement enabled advice to be sought and patient problems and treatment to be discussed by the wider team when necessary.

Staff and managers said medical staff normally adhered to the requirement to inform them in advance of planned leave and absence. We were told that other medical staff normally provided cover during absence, to avoid cancelling clinics and reduce waiting times for appointments.

Managers told us advanced nurse practitioners were being introduced to support clinics and reduce the workload of medical staff. Pathways to support this were being developed and discussed at clinical governance meetings.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely.

However, they were not always easily available to those providing care. Access to investigations that were undertaken at other hospitals such as the referring hospital were not always available when needed and timely access to the most up to date clinical information was not always available due to the time taken for outpatient letters to be typed.

Patient notes were comprehensive and staff could access them easily in most cases. However, there were delays in access to the results of investigations undertaken at different hospital sites. Patient notes for patients receiving care at MVCC were stored on site and were accessible when required. Archived notes were stored off site in a separate facility, although were available within two hours of request. Reception staff said clinic clerks accessed the notes from medical records and they were brought to the outpatient department in readiness for the clinic the following day. Medical, nursing and reception staff reported good availability of patient notes and told us it was unusual for there to be any delays in accessing them. Managers reported they had not completed a recent audit of notes availability for outpatient clinics. They said they had reviewed the medical
records department and commenced an improvement project in June 2019. Part of the project was to complete an ongoing audit of availability of records until with project was completed and this was to be started shortly.

The majority of patient records were paper based, although investigations such as scans and blood results were stored electronically. Medical staff said they experienced delays of several days in accessing scans, X rays and other investigations that were undertaken at other hospitals. There was no real time connection of the radiology systems between MVCC and the surrounding hospitals in their catchment area. Staff told us this inevitably created delays for patients.

We reviewed 12 patient records. Entries were legible, dated, timed and signed and the designation of the person making the entry was usually recorded. We found entries were mostly clear, with a diagnosis and treatment plan. Progress was recorded at each patient visit and when patients were receiving chemotherapy there was access to the chemotherapy review tool completed at the chemotherapy visit. Staff recorded discussions with patients and relatives and different professionals recorded their input contemporaneously.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Timely access to the latest outpatient review for nurses providing the 24 hour advice line for patients, was not always possible. Records were readily available to staff from the medical record department at MVCC. When patients were seen in the outpatient department a letter was sent to the patient’s GP providing details of the consultation and treatment plan. This was also copied to the patient and to other professionals involved in the patient’s care. Staff told us clinic letters were typed and sent out approximately two to three weeks after the appointment, depending on the level of secretarial support available. As a result, nurses operating the 24 hour advice line for patients experiencing problems with their treatment could not access the most recent clinic letter and there was a risk they could make decisions not based on the latest clinical information. Steps were being taken to reduce the time frame for production of clinic letters and audits completed by the trust showed that in June 2019 and July 2019 the average turnaround time for clinics was 6 days and 9 days respectively; the longest response time in June 2019 was 17 days and 26 days in July 2019.

Records were stored securely. Records were stored behind the reception desk until they were collected by nursing staff from the clinics. They were then transferred to the hub rooms in the department, which were locked when not attended. No notes were stored in consulting rooms.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Suitable arrangements were in place for the safe management of medicines as outlined in the trust’s medicines policy. This included obtaining, prescribing, recording, security, dispensing, safe administration and disposal. Staff followed agreed protocols when prescribing chemotherapy. The service used a chemotherapy electronic prescribing and patient management and scheduling system to increase the safety of chemotherapy prescribing and management.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacists were based in the outpatient clinics and saw patients when starting chemotherapy and when they were followed up to clinically assess the patient and ensure the chemotherapy was safely prescribed. They reviewed medicines on a regular basis. Patients told us their medicines were explained to them, along with the possible side effects.
Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored safely in locked cupboards within locked rooms. The temperature of the room and the refrigerator used to store medicines was checked daily. Records showed they were within acceptable limits and action was taken to escalate to pharmacy and the maintenance team where necessary. The pharmacy team checked medicines stored in the department and their expiry dates. We looked at a sample of Controlled drugs and saw that they were stored in accordance with requirements and nursing staff checked these daily.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were cascaded by the pharmacy team.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Nursing and medical staff we spoke with, were aware of what an incident was, and the importance of reporting incidents. The trust used an electronic incident reporting system and staff were confident in using it.

Staff reported incidents that they should report. For example, a member of staff told us of a medicines error they had reported and changes that were made to the checking process as a result.

**Never Events**

The service had no never events.

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

From June 2018 to May 2019, the trust reported no incidents that were classified as a never event for outpatients.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

**Staff reported serious incidents clearly and in line with trust policy.**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from June 2018 to May 2019. One of the incidents was classified as a treatment delay meeting SI criteria and the other was classified as a diagnostic incident including delay meeting SI criteria (including failure to act on test results).

*(Source: Strategic Executive Information System (STEIS))*
The trust informed us that these incidents did not occur at MVCC; they occurred within another of the trust’s hospitals. We reviewed the investigation of another serious incident that had occurred at MVCC for a patient who was initially admitted to the ward from the outpatient department and saw it had been reported and investigated appropriately.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed the communication with the relatives of a patient following an incident and saw relatives were involved in the investigation process and the duty of candour principles were applied. Information about the duty of candour was displayed in the hub rooms.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback when they reported an incident and we observed the ‘top three’ incidents for the outpatient service were displayed in the department, along with actions taken as a result.

Staff met to discuss the feedback and look at improvements to patient care. The outpatient staff met twice daily for a safety huddle and incidents and feedback from incidents were highlighted at the huddle. There were also regular team meetings and staff said they discussed improvement to patient care at the meetings.

There was evidence that changes had been made as a result of feedback. Call bells were installed in the consulting rooms and the procedure room to increased patient safety and ensure assistance could be summoned in an emergency.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the notes of a root cause analysis of a serious incident and found it had been systematically investigated and the learning points identified. An action plan was put into place to address the concerns raised. The patient’s relatives raised questions which were documented and investigated. Following this the relatives were invited in to discuss the outcome of the investigation.

Managers debriefed and supported staff after any serious incident. A member of staff told us they had discussed an incident within clinical supervision. This enabled them to reflect on the issues and debrief.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data for the cancer centre was displayed in the outpatient department for staff and patients to see. The safety thermometer data showed the services achieved 100% harm free care during June 2019.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. However, managers did not always check to make sure staff followed guidance.
Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, audits to check compliance with guidance were not always completed. 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.

Staff had access to, and were familiar with, National Institute of health and Care Excellence (NICE) guidance relevant to their specialty. For example, a member of staff told us they adhered to NICE guidance in the referral of patients with cord compression to neurosurgery, whilst another referred to adherence to NICE guidance (NG36) for the assessment and management of upper aerodigestive tract cancer. Others spoke about following NICE guidance for lymphoma, myeloma and anti-coagulation. When patients presented with metastatic disease, NICE guidance was followed. However, audits to assess compliance with guidance were not completed. A consultant said the number of patients treated was low for their specialty and therefore audits were not completed; however, audits of compliance were completed at another tertiary centre and these captured the work load of patients seen at MVCC. A range of proformas were used to ensure patients were assessed systematically in line with best practice. For example, a proforma for head and neck cancer patients was completed weekly by staff, the systemic anti-cancer therapy (SACT) consultation checklist was used for patients receiving chemotherapy and the latest version of the national radiotherapy toxicity grading system was used.

All chemotherapy protocols were approved by the lead pharmacist prior to use on the chemotherapy electronic prescribing and patient management and scheduling system. If consultants felt there needed to vary the protocol, they were required to complete an application and it would be assessed to look at whether it was within NICE guidelines and within the funding criteria.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were aware of the requirements.

Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff spoke about the psychological and emotional needs of patients and there was a recognition of the support people needed to ‘move on’ after their treatment had finished. Patients were able to access services at the Lynda Jackson centre within MVCC, in addition to the support they received from their core medical and nursing staff. This was a drop-in centre where people could access information and support about all aspects of their cancer care and treatment. It offered a calm and relaxing environment for people affected by cancer and provided counselling sessions, complementary therapies, relaxation sessions and workshops and courses to help people move on when their treatment had finished.

**Nutrition and hydration**

**Staff ensured patients were able to eat and drink enough to meet their needs and improve their health. Patients had access to dietary advice when needed.**

A café was situated in the outpatient department waiting area for people to access food and drink if they needed it. However, it was only open from 10am to 3pm and patients who attended the department for appointments outside these hours told us this was not ideal. A vending machine was available and drinking water was available. Staff were alert to patient’s hydration needs and offered them water when needed.
Specialist support from staff such as dieticians was available for patients who needed it. Dietitians were available within key clinics such as for head and neck cancer, lung cancer and gastrointestinal cancers. In addition, patients could be referred to the service when needed. A patient told us they had been given advice after surgery about diet and advised about the availability of protein drinks. They said they had also been given information leaflets to provide further information. They said they had been given advice about mouth ulcers and advised to eat soft food and shakes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and prescribed pain relief when needed.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numeric rating scale or visual analogue scale to assess patients’ pain. A consultant we spoke with said they discussed patient’s pain as a team and considered the best way to manage their pain. Another consultant spoke about using the generic palliative care regime if appropriate and told us they could refer to the enhanced supportive care team. Others spoke of involving specialist pain nurses.

A patient told us they had experienced nerve pain following surgery and during their current treatment. They told us the clinical nurse specialist had arranged for them to be prescribed some new medicines and had explained how to manage their current medicines to best effect. They also provided them with contact details for the pain specialist nurse. They told us, “I was never left adrift.”

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. There were no national outcome audits specific to outpatient management of cancer specialties. However, the service submitted their data to the national systemic anti-cancer therapy database (SACT). This database collected data from all NHS England providers and improves understanding of treatment patterns and outcomes on a national scale. A consultant said the database showed performance in the middle of the range for MVCC. The trust did not provide evidence to support this, however, demonstrated the collection of SACT data was discussed at quality improvement team meetings for chemotherapy. Another consultant commented that most of the treatment provided was palliative and it was difficult to identify outcome measures for palliative care.

Managers did not carry out a comprehensive audit programme, however they audited outpatient performance measures that impacted on patient experience and outcomes.

There was no identified clinical audit programme to assess the effectiveness or outcomes of care and treatment provided in outpatient services. However, each individual’s outcomes of treatments provided, including targeted drug therapy such as Denosumab and hormone injections were assessed by consultants. The results were not audited to provide a systematic assessment of clinical outcomes collectively.
The service had an outpatient dashboard which managers used to monitor referral to treatment times, 'did not attend' rates, clinic cancellations, slot utilisation and other key measures. The service also monitored clinical correspondence transcription times. This performance data was discussed at monthly meetings.

**Follow-up to new rate**

**The ratio of follow up appointments to new patients was higher than the England average.**

From February 2018 to January 2019 the follow-up to new rate for Mount Vernon Cancer Centre was higher than the England average.

**Follow-up to new rate, East and North Hertfordshire NHS Trust.**

Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

The higher than average follow up rate, was due to the complexity of patients seen at MVCC and the regular appointments for the high number of patients undergoing chemotherapy. Managers told us they were considering follow up appointments to identify whether they could be reduced, as this would also impact on the ability to schedule new patients and reduce waiting times for first appointments.

Managers used information from audits to improve care and treatment when these were measured. They shared and made sure staff understood information from the audits. Improvement was checked and monitored. Measures such as referral to treatment times and other dashboard indicators were discussed at clinical governance and operational meetings and ways in which they could be improved were discussed. A consultant commented that opportunities to discuss the management of specific diagnostic groups at weekly clinical governance meetings had reduced as there was more focus on operational management issues. As a result, lessons learned from other disease sites that might have been transferable were not always shared and dissemination of knowledge was reduced.

Many patients were given the opportunity to be involved in clinical trials and research to improve clinical outcomes. Most specialties were actively involved in several multi-centre, national, or international clinical trials. All patients who met the criteria for each clinical trial were offered the
opportunity to participate. The service employed research nurses to provide information to patients and coordinate the trials. Patients were given full explanations of what was involved and the treatment options, to enable them to make an informed decision about participation. However, the external strategic review completed at MCVV stated that clinical trials should be embedded in the clinical service with equitable access for all patients and this was not the case at MVCC.

The service had gained CHKS and ISO 9000 accreditation.

**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 and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All clinics were run by clinicians with the appropriate experience and training in the field. Most registered nurses had a specialist qualification and/or substantial experience in cancer care. Medical staff and clinical nurse specialists had access to advanced communications skills training to ensure they were able to break bad news sensitively. The trust reported that 64% of consultants and 50% of the clinical nurse specialists were trained in advanced communications skills. There had been a decrease in numbers due to an influx of new clinical nurse specialists and new consultants. However, they were able to access advanced communications skills training through the local hospice and the education lead was coordinating training for consultants and clinical nurse specialists, which was due to take place over the next six months. A Level 2 psychological skills course, was being re-established, facilitated by the in house psychology team. This was mandatory for all the clinical nurse specialists and senior radiographers. Nursing staff within the outpatient service had undertaken some form of communications training and some of the registered nurses had undertaken advanced communication skills training. They told us they had also received some specialty specific training from consultants and clinical nurse specialists.

Pharmacy provided an e-prescribing team and pharmacists with specialist knowledge of chemotherapy and prescribing for cancer treatments. Some pharmacists were independent non-medical prescribers.

Managers gave all new staff a full induction tailored to their role before they started work. Medical, nursing and pharmacy staff told us they had received a comprehensive trust and local induction. We spoke with two volunteers who had also attended trust induction and a full training programme prior to starting work.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work.

**Mount Vernon Cancer Centre**

From April 2018 to March 2019, 100% of staff within outpatients at the Mount Vernon Cancer Centre received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
</tbody>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL Page 354
<table>
<thead>
<tr>
<th>Administrative and Clerical</th>
<th>1</th>
<th>1</th>
<th>100.0%</th>
<th>90%</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Other staff we spoke with, for example, research nurses, pharmacists, and medical staff said they had received an annual appraisal.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Clinical nurse specialists said they had access to supervision and some spoke about attending group supervision sessions. Junior medical staff were allocated clinical and educational supervisors. They told us they were encouraged to attend training courses and were given time to undertake them.

There were no clinical educators to support staff learning and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings were held monthly within the outpatient service and reception staff said they had team meetings three to four times a year. Notes of the meetings showed a wide range of issues were discussed related to improvements in the service and training completion.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff told us their training and development needs were discussed at their appraisal. A relatively newly qualified pharmacist told us they had been given the opportunity to enrol in a diploma to obtain the qualifications needed for a specialist role. The service was creating some trainee clinical nurse specialist roles and was providing a training programme to enable them to develop the knowledge and skills needed for a full clinical nurse specialist. They were also piloting new roles such as a band four care coordinator role. These staff were funded by the Macmillan charity and were provided with a structured training package and supervision.

Managers identified poor staff performance promptly and supported staff to improve. During the inspection we were made aware of two members of staff where performance issues had been identified and staff were being supported through this.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were recruited safely and received initial training and continuing support. Two volunteers we spoke with were enthusiastic about the training they had been provided with on commencing at the service. The outpatient service utilised volunteers in a range of capacities, including accompanying patients from reception to their clinic as this was not always straightforward. Two volunteers told us about the interactive approach to training on way-finding they had been provided with, to ensure they were able to assist patients appropriately. They also said they had regular opportunities to meet together and discuss best practice and new ideas.

**Multidisciplinary working**

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, decisions made at
multi-disciplinary team meetings held in other trusts were not always evident in patient’s records.

Medical staff attended regular formal multidisciplinary meetings to discuss patients and improve their care. However, very few multi-disciplinary team (MDT) meetings were chaired and coordinated by the consultant oncologists at MVCC and the overall responsibility for the patient pathway remained with the referring hospital where patients had received initial surgery. Medical staff supported formal multidisciplinary meetings in surrounding trusts, providing specialist oncology representation to these meetings. A consultant said that all decisions about the patients’ treatment were ratified at MDT meetings and there was a good flow of information between teams, although they were not always on site. However, we reviewed the 10 patient records and found some contained information (in the form of clinic letters or MDT meeting records) about the outcome of MDT meetings at other hospitals, whilst in others, there was no evidence of MDTs.

Patients could not always see all the health professionals involved in their care at one-stop clinics. Few specialties had one stop clinics. However, staff provided us with information about clinics in which there was multi-professional involvement to reduce the number of visits the patient made. For example, a skin clinic was held jointly between a dermatologist and oncologist, dietitians were involved in the clinics for several specialties and clinical nurse specialists were regularly involved in clinics alongside medical staff.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Consultants provided a clinical outreach service for surrounding trusts, including oversight of local delivery of chemotherapy in several of these sites.

Informal multidisciplinary discussions between the professionals at MVCC regularly occurred and we observed examples of good multi-disciplinary working. For example, between medical staff, pharmacists and clinical nurse specialists.

Managers were developing services to support the delivery of holistic needs assessments to improve communication between cancer services, patients and primary care. Managers told us this was an area of development and they were working with the information technology department to set up an electronic needs assessment. Paper based assessments were being completed and they were developing a stratified pathway which would have an end of treatment assessment and well-being programme.

Staff referred patients for mental health assessments when they showed signs of mental ill health, including depression.

Seven-day services

Key services were available seven days a week to support timely patient care through referrals to inpatient services. However, outpatient clinics were not available seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. These were available through acute services when necessary. Nursing staff managed a central ‘hub’ to provide 24 hour a day seven day a week access to advice and support for patients experiencing problems during treatment. Staff would triage the patients and arrange for admission to MVCC if necessary, an urgent review of the patient, accelerated outpatient appointment, or advise the patient to attend their local hospital.

At the time of the inspection clinics were generally scheduled weekdays between 9am and 5pm.
A member of staff said they had previously tried evening clinics, but they had not been popular with patients. However, there were plans in progress to increase the opening hours to 8am to 8pm and introduce Saturday clinics. This would require changes to working hours and consultation with staff.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support in patient areas. Patients were provided with a wealth of information to help support them through cancer treatment pathway, manage their symptoms and promote their well-being. The Lynda Jackson Centre within MVCC provided relaxation sessions, complementary therapies and workshops and courses for patients. Some of these were focused on managing the side effects of treatments, for example headwear workshops for people experiencing hair loss and skin care and make up workshops to boost confidence and well-being; whilst others were designed to help people move on when treatment had finished.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle. Clinical nurse specialists maintained contact with patients throughout their treatment and provided advice and support to maintain their health during treatments and following treatment. Patients were given an appointment to see their clinical nurse specialist after their treatment was completed to enable them to move on and to promote a healthy lifestyle.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had a good understanding of the need to assess patient’s capacity to make decisions when necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke with said they had been asked for their consent prior to interventions such as chemotherapy, radiotherapy, immunotherapy and also prior to the insertion of intravenous lines. They told us they were given full explanations, together with the risks and benefits. When alternative options were available these were discussed with them.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff explained that when patients were unable to give informed consent, they were supported to give their views and the patient’s relatives and carers were involved to provide further information about the patient’s wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. When patients were offered treatment or the opportunity to participate in a clinical trial, full explanations were given by the medical and nursing staff and the patient was provided with written information.
to take away. Staff then rang the patient a few days later, or they returned for another appointment to discuss it further and gain their consent.

Staff clearly recorded consent in the patients’ records. Seven sets of patient records we reviewed contained signed consent forms for various procedures which were appropriately completed. When patients had a lasting power of attorney in place for health and welfare the attorney was consulted. Trust audits of consent for radiotherapy showed good compliance with the requirements.

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

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Mount Vernon Cancer Centre**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at the Mount Vernon Cancer Centre for registered nurses in outpatients is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|----------------------|--------------------------|-----------------|-----------------|-----------------|
|                      | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Adults Level 1 - 2 Years | 5 | 5 | 100.0% | 90% | Yes |
| Safeguarding Adults Level 2 - 2 Years | 5 | 5 | 100.0% | 90% | Yes |

In outpatients at the Mount Vernon Cancer Centre the target was met for both MCA/DOLS training modules for which registered nurses were eligible.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers did not monitor how well the Mental Capacity Act was complied with.
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff protected patient’s privacy and dignity when providing care. A patient told us privacy was good. They told us chaperones were available and staff made sure patients were covered when examining them. They said they were treated with great respect. Nursing staff said they were available to chaperone patients when they needed a physical examination and medical staff offered patients a chaperone. However, there were no notices on display to inform patients they could ask for a chaperone.

Patients said staff treated them well and with kindness. Patients praised staff for their kindness and consideration. A patient said, “I have great faith and feel safe in this hospital. I have been looked after very well.” Another patient said, “Care is absolutely amazing. Staff are considerate, gentle and very attentive.” We noted staff knew many of the patients visiting the department, spoke to them by name and enquired into their well-being when they saw them coming into the department, or when they checked on patients in the waiting area. In the same way, staff in reception recognised patients and welcomed them in a friendly and polite manner.

Staff followed policy to keep patient care and treatment confidential. Staff took care to keep patient information confidential and conversations with patients were undertaken in individual consulting rooms with the door closed. However, the reception desks where patients booked in and made further appointments, were open and other patients waiting to see the receptionist could over hear the conversation at times. Staff offered a private room if a patient wished to discuss sensitive information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We spoke with staff about the individual needs of patients and how they met these. Staff showed empathy and understanding for people and the way their anxiety and health affected their behaviour at times.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. On most occasions clinical nurse specialists accompanied medical staff when they had to give distressing news to patients. This enabled the nurses to be aware of exactly what the doctor had said and to spend time with the patient afterwards. Patients told us they were given time to ask questions and several patients commented on positively about the presence of the specialist nurses who spent time with them to provide information and support and answer any questions. A patient said, “They have been terrific; they hold your hand and talk to you. They are open with me.
and gave me information from the start.” Others spoke about the way the specialist nurses had built relationships with them and visited them when they attended for treatments, to provide support.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Although space was at a premium, staff ensured that when distressing news was going to be delivered, consideration was given to ensuring this was done in a private area where they could spend time afterwards without having to hurry them. Staff utilised space in an area opposite the department if a patient became distressed and a consulting room was not immediately available. The Lynda Jackson unit within the MVCC provided a drop in service for patients and relatives where they were provided with emotional support in a suitable area.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Medical staff undertook advanced communications training and all patients with one exception said medical staff had dealt with difficult issues, sensitively and with compassion. However, one patient told us they had found a junior doctor blunt with poor interpersonal skills, at their first consultation. They told us other staff were sensitive and helpful.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. They offered patients emotional support and practical advice on benefits and financial assistance in addition to emotional support.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. All the patients we spoke with were aware of the plans for their care and treatment. They said staff gave clear explanations and took time to answer their questions. A patient said a doctor had drawn a picture in order to explain their symptoms. Patients received a copy of the letters sent to their GP following their outpatient appointments and they were given the opportunity to record their consultation if they wished, so they could listen to it again afterwards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed leaflets were available within the waiting areas, encouraging patients to provide feedback on their experience. There were also additional experience surveys for specific specialties for patients to complete to provide feedback. The trust provided information about a range of surveys and the results from these.

Staff supported patients to make informed decisions about their care. Staff provided information and explanations for patients and the opportunity to ask questions. They checked patient’s understanding prior to asking them to make decisions. For example, patients were given the opportunity to think about their treatment options or whether they wanted to participate in clinical trials. They were encouraged to ask any questions in relation to this.

The feedback from the Friends and Family Test was positive. Many patients attended the outpatient department frequently during their care and treatment. Staff told us that patients did not always want to complete a questionnaire as they were asked on a frequent basis. In order to respond to this friends and family test questionnaires were given to all patients on one day per week. This reduced the number of times patients were asked to complete a questionnaire.
Recommender scores were high with between 95% and 100% of patients recommending the service to their family and friends.

### Is the service responsive?

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

The service did not always provide care in a way that met the needs of local people and the communities served. However, it worked with others in the wider system and local organisations to plan care.

Managers were starting to plan and organise services so they met the changing needs of the local population. At the last inspection of MVCC inpatient services in 2018, issues were identified in relation to the planning of cancer services to meet the needs of the local population. Following an external review of cancer services at MVCC, managers were putting plans in place to move forward with the recommendations, which included outpatient services. They had a draft action plan, with timescales for most actions to be complete by the end of August 2019. There was a steering group with a large membership including stakeholders such as the local clinical commissioning group, representatives from tertiary cancer centres and neighbouring trusts.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Staff said they tried to reduce repeat attendances and coordinate tests wherever possible. They used the procedure room in the department to enable patients to have blood tests in the clinic and to undertake ECGs (heart tracings) during the visit rather than booking a separate appointment. A patient told us their scans and blood tests were arranged for the same day, so they did not have to come in twice.

Staff knew about and understood the standards for mixed sex accommodation and knew when to undress in advance. Therefore, same sex accommodation requirements were met.

Facilities and premises were not always appropriate for the services being delivered. The outpatient department had 16 clinic rooms and two small waiting rooms, both of which were inadequate to meet demand. The building was not in a good state of repair and the environment was not suitable for purpose. This was on the service’s risk register. There was more than one entrance to the outpatient department and signage was not always in place, or clear. When entering the department through one entrance, patients passed the waiting room and clinic rooms before reaching the reception desk. A patient commented that there was a lack of signage and they had found it difficult to find their way to the department on their first visit. A patient using a wheelchair said the clinics were very spread out and this made it difficult for people with mobility problems. However, they said there were accessible toilet facilities. Waiting room space was limited and crowded at times. Managers said they had developed some plans with the community engagement team to increase waiting space and provide a quiet area, utilising some outside space. They had planned to use volunteers to bring patients to the consulting rooms when staff were ready to see them. They told us they had tried a paging system in the past but due to the fabric of the building, the pagers were unreliable.

In addition, there were capacity issues which impacted on the flow of patients and reduced the efficiency of clinics. The number of clinic rooms was not always sufficient to accommodate the number of clinicians seeing patients, leading to delays in the clinic. On days when this was identified as being an issue, managers tried to access additional accommodation in adjacent
facilities if they were available. The service did not meet the Royal College guidance on the amount of time allowed for appointments and this was being reviewed in conjunction with the consultants. However, extended appointment times would have further impacted on capacity.

Patients were sent information prior to their first appointment with details of the address, maps, transport information and car parking facilities. There was reduced parking charges for patients attending regularly.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Volunteers were available in the outpatient reception to guide and accompany patients when needed. Volunteers told us they had learned to recognise those patients who were unfamiliar with the area and might need additional support. Staff checked patients in the waiting room regularly and identified those in need of additional support or intervention. They responded to the individual needs or circumstances for each patient.

Managers monitored and took action to minimise missed appointments. Reminder texts were sent to patients who had provided their mobile phone details, prior to the appointment. However, staff told us that when changes were made to the appointment this was not always picked up by the system and the text provided the original time; this caused confusion for some patients. Follow up appointments were booked at the end of the previous visit, thus enabling patients to have a degree of choice in their appointment date and time so that they could plan ahead. Patients told us they could telephone and amend their appointment time if necessary and staff tried to accommodate changes whenever possible. A patient said, “I am given a choice of appointments and staff try to fit the appointment to suit us, they are very helpful.”

**Did not attend rate**

From February 2018 to January 2019 the did not attend rate for Mount Vernon Cancer Centre decreased over time. From September 2018 to January 2019, the rate was lower than the England average.

The chart below shows the did not attend rate over time.

**Proportion of patients who did not attend appointment, East and North Hertfordshire NHS Trust**

![Graph showing did not attend rate over time for different sites, with a note that spells assigned to the site name “East and North Hertfordshire NHS Trust” are those not assigned to a specific site in the data.]

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.
Managers ensured that patients who did not attend appointments were contacted. Reception staff provided the patient notes of the patients who did not attend and these were sent to the medical secretaries for follow up. Staff said that in cancer services it was unusual for patients not to attend their appointments. When patients appeared to have missed their appointment, it was frequently due to them being admitted to hospital as an inpatient, or an appointment had been brought forward, or changed, due to issues with their cancer treatment.

The service relieved pressure on other departments when they could treat patients in a day. When patients required blood tests or other investigations that could be undertaken in the procedure room in the outpatient department, staff tried to accommodate this to reduce visits for the patients and relieve pressure on other services.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a dementia champion and a learning disabilities champion. Staff had access to two members of staff who formed the health liaison team and provided support to patients with a learning disability. They provided allocated time with patients attending the department, stayed with them throughout their visit and supported them through their journey in the department. Staff told us they tried to reduce waiting times for patients with complex needs. At the time of the inspection, there was no separate quiet waiting facilities for those whose might become anxious or distressed in noisy, crowded environments.

The department was not designed to meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff said they utilised these documents when patients attended with them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff said they were able to provide information in a range of different formats including large print if they were requested. MVCC had an accessibility team and information was available to explain the service and provide information in a variety of formats including, large print, braille, audio or sign language (videos). Patients could contact the team for an assessment of their needs.

The service had information leaflets available in languages spoken by the patients and local community. We did not see any information leaflets in different languages on display during our inspection visit and information leaflets we reviewed did not provide information as to how these could be obtained in other languages. However, the trust provided us with examples of information for patients in Polish and Arabic and said information was available in other languages as required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreters were usually pre-booked when the outpatient appointment was made. Medical and nursing staff said they had not experienced any difficulties with accessing
interpreters when they were needed. In the situation when an interpreter was needed urgently, staff said there was a list of staff available who were able to interpret.

Patients were able to purchase food and drink from a café in the department. A vending machine with snacks and drinking water was available.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards. The percentage of patients waiting over 62 days from urgent referral to first definitive treatment was above the England average and those waiting over 31 days from diagnosis to first definitive treatment was just below the England average. Patients also sometimes experienced extended waits when clinics ran late.

Managers monitored waiting times and but did not always ensure patients could access services and receive treatment within agreed timeframes and national targets.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust’s performance has been above the national standard and the England average performance from July 2018 to March 2019. The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust failed to meet the 96% operational standard and performed worse than the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all periods from April 2018 to March 2019. The performance over time is shown in the graph below.
Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), East and North Hertfordshire NHS Trust

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust failed to meet the 85% operational standard and performed worse than the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, East and North Hertfordshire NHS Trust

(Source: NHS England – Cancer Waits)

The data above includes all treatment types for all types of cancer by quarter. Monthly data was also available from NHS England broken down by treatment type with different targets for different types of treatment. The trust told us their 31 day waiting time had been compliant for the last 11 months for radiotherapy and chemotherapy (apart from one month – May 2019 when the chemotherapy 31 day subsequent treatment compliance was below the 98% target by 0.2%).

The trust had a process in place to monitor and improve compliance with the 31 day and 62 day referral to treatment times. This included obtaining patient tracking list information and reviewing it at weekly meetings, to consider waiting times and address any individual delays. In relation to 62
day waits, the trust told us there were actions plans for each tumour site which covered the actions required to support the 62 day patient tracking list improvement trajectory.

The trust was unable to provide data relating to the number of patients whose appointment date was set beyond the target date for review. They said they were working with the provider of the patient administration system to obtain access to this data. However, they provided information on the number of patients seen for one week (24 to 30 July 2019), who were coded as requiring a follow up appointment, but had no follow up appointment booked. There were 96 patients for medical oncology and 209 for clinical oncology (radiotherapy).

Managers and staff did not always make sure patients did not stay longer than they needed to. At our last inspection in March 2016, we found clinics regularly over-ran and some patients had to wait a long time to be seen. At this inspection we found this remained unchanged. Outpatient clinics did not always run on time and patients sometimes experienced waits and were seen beyond their appointment time. Staff told us patients attending some clinics regularly experienced waits of up to an hour and during the inspection we observed delays of over an hour for one clinic and an hour and a half for another clinic. Staff said additional patients often had to be given an urgent appointment if they were having issues with their chemotherapy and this led to clinics being over booked. A member of staff said, “Everyone gets the time they need, and we have a lot of patients with complex needs. Most patients are understanding of this.” Patients we spoke with, gave us variable feedback about delays to appointments. Some patients said they were mostly seen within 15 minutes, whilst others spoke of waits of up to two hours. We noted that the main theme arising from patient experience surveys in the outpatient service was waiting times.

Managers said they were working with consultants to increase the time slots of appointments to bring them in line with Royal College guidance; however, some consultants expressed concerns that some patients did not require this amount of time and it would lead to reductions in the number of patients seen and extended referral to treatment times. Waiting times at clinics were not audited.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us that if consultants were absent their clinic was mostly covered by colleagues to reduce cancellations. A senior nurse said the service was introducing ‘8,4,2’ meetings to look ahead at clinic activity and resolve issues. Data provided by the trust indicated this was part of the weekly operational meeting. Managers reported a total of five clinics at MVCC were cancelled within six weeks of the appointment date for the three months from May 2019 to July 2019. These were due to consultant annual leave or study leave.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff supported patients when they were referred or transferred between services. When patients became unwell in the outpatient department staff supported them and arranged for their admission to the inpatient wards or transfer to another hospital when this was necessary. A decision flow chart was available to guide staff in the process.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, the time taken to respond to complaints did not always meet the trust target.
Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives we spoke with said they would raise concerns with staff in the department or through the Patient Advice and Liaison service (PALS).

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. They told us they worked proactively to resolve any issues at the time.

Summary of complaints

Trust level

From April 2018 to March 2019, the trust received 333 complaints in relation to outpatients at the trust (34.4% of total complaints received by the trust). The trust took an average of 51.1 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed within 35 working days.

Managers investigated complaints and identified themes.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>119</td>
<td>35.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>106</td>
<td>31.8%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>68</td>
<td>20.4%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>35</td>
<td>10.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Note: Due to the format of the data received we were unable to breakdown by complaints by site level. So, this data is trust wide.

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

Senior nurses said complaints in the outpatient department at MVCC were usually about waiting times. They said the hourly rounds of patients in the waiting room enabled them to keep patients informed of waiting times and to address any other concerns they had. They said that complaints were addressed at the time if possible and they said they completed a verbal complaint form with the details of the complaint and actions to address when this was needed.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Information about complaints and the themes from complaints was displayed in the department. Themes identified were delays in appointments, quality of care and poor communication.

Number of compliments made to the trust
From April 2018 to March 2019, there were three compliments about outpatients at the trust (6.4% of the total compliments received across the trust). However, none of them related to MVCC.

The trust stated that compliments were received via the CEO office, these were responded to and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments via their social media platforms and direct compliments to areas across the trust. The trust was currently developing a consistent approach on how to capture, record and share themes and trends that related to compliments and praise for services.

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

Is the service well-led?

Leadership

Leaders did not always have the skills and abilities to run the service. Staff did not feel leaders always understood and managed the priorities and issues the service faced. However, leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The outpatient service at MVCC was managed within the cancer services division, consisting of a divisional chair, divisional director and head of nursing. Supporting the divisional chair was a clinical director. Sitting under this team were triumvirates (threesomes) for each department. For outpatient services, this consisted of a consultant, matron and service manager.

Staff commented on the changes to the divisional leadership team that had taken place over the previous year and the fact there was an increased management presence on-site. This was viewed positively by staff. However, there was some confusion among staff, including medical staff, about the roles of the divisional chair and the clinical director and the fact the clinical director was available at the MVCC for one day per week. We found a that there was a disconnection between the senior management team and senior medical staff that impacted on the introduction and management of change. Communication and involvement, two key factors in successful change management were not fully effective. Senior medical staff spoke about a lack or failure of leadership. Some medical staff said that whilst there was increased presence on site, they did not feel some managers understood the service. One member of staff gave an example of the linear accelerators (used in some cancer treatment) which had a limited life span and no funding had been allocated on a regular basis, to allow them to be replaced. A consultant said they used to be more involved, but in recent times there had been less input and influence on changes, causing frustration for clinicians. Senior managers identified negativity and a lack of engagement from some consultants; they told us there were some performance issues which were being managed.

An external strategic review of cancer services at MVCC, commissioned by NHS England, was completed and the report dated July 2019, identified that a number of reviews of cancer services at MVCC had been undertaken and had not resulted in substantial changes. They identified the complexity of the issues and changes in oncology treatments provided which had made resolution difficult. However, the issues they had identified, including the depletion in acute services needed to support cancer treatment, the provision of poor quality accommodation, equipment reaching the...
end of its life span with no replacement programme and lack of IT connectivity, were evidence of a lack of oversight and leadership of the services over a period of time. Additionally, there had been a lack of ability or drive to influence other stakeholders, to benefit the development of services at MVCC. The report recommended that a full time clinical director of oncology based at the site should be appointed to manage the transition to a new configuration of services. A senior manager we spoke with told us they had fulfilled this requirement with the appointment of a divisional clinical chair, supported by a part time clinical director.

The senior nursing and management team were visible on site and had a focus on delivering change and working to achieve the recommendations of the external review. They spoke about the development of new roles and new ways of working within the outpatient service. Staff expressed a view that although other reviews had not resulted in substantial change, on this occasion they felt there was a willingness to implement the recommendations. Staff told us they had seen these managers more over the last few months; however, the chief executive and director of nursing were not visible and only visited three to four times a year. A member of staff said the cancer centre was not valued by the trust management team and they felt like an ‘appendage’.

The outpatient matron was supportive and effective, and under the leadership of the matron and band six sister, the nursing team were a cohesive team. Staff said the matron was approachable and had good people management skills. There were monthly staff meetings and minutes of the meetings showed key information was cascaded to staff and there was feedback about incidents, complaints and changes to practice.

Vision and strategy

The service had a vision for what it wanted to achieve and was working with relevant stakeholders to develop an agreed strategy and action plan. The vision and strategy were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However, the strategy was not focused on the sustainability of the service as they had not considered the replacement of aging equipment.

The trust had a quality strategy for 2019 to 2024 aligned to the trust values. Staff were aware of the trust values. There was information about the trust strategy displayed within the outpatient department.

There was an MVCC clinical strategy for 2018 to 2022 with four key aims:

- To deliver high quality, safe, efficient and innovative services
- With partners transform how cancer care is provided
- Harness patient views and technology to transform the environment in which we deliver care
- Attract and retain high quality, expert staff supported by a culture to learn and thrive.

A clinical strategy delivery group monitored progress of an action plan to deliver these aims. Reports from MVCC to the trust finance and performance committee also contained information on actions being taken within the service to progress these aims.

The external strategic review of cancer services at MVCC had resulted in recommendations which provided two preferred options for the future direction and configuration of services. The trust were
working with key stakeholders to progress the recommendations of the strategic review and implement the preferred options. They had developed a draft action plan that identified the key steps towards implementation of the recommendations.

**Culture**

Staff did not always feel respected, supported and valued. Some staff felt disempowered and unable to influence management decision making.

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Despite the uncertainty about the future configuration of services and the daily challenges facing the service, staff were committed to providing the highest quality of care they could for patients and worked together to achieve this. They acted as advocates for patients and did everything they could to improve patient’s well-being.

They were open and transparent when things went wrong and fulfilled the requirements of the duty of candour. Documentation related to the investigation of incidents, showed that patients were involved if they wished and the results of the investigation were communicated to them.

Support was provided to staff where they could discuss the emotional aspects of caring for people with cancer. This was provided by the management team and through clinical supervision. Schwartz rounds had lapsed for a time but were being re-introduced. A Schwartz round is a structured forum which provides an opportunity for staff from all disciplines to reflect on the emotional aspects of their work by discussing specific cases or themes from their work.

However, staff did not always feel their voices were heard and felt that management decision making was not inclusive. They did not feel senior managers within the trust understood the service and felt the cancer service was not valued by the trust management team.

Junior doctors said there was not facilities for them, such as is normally provided. There was no office for them and no rest room; there was no space to store personal belongings. The hospital canteen was only open restricted hours and at weekends food and drink was only available from vending machines. A junior doctor said they were not treated humanely.

**Governance**

Leaders operated governance processes, throughout the service and with partner organisations although there was limited evidence of their effectiveness. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers held weekly clinical governance meetings. The focus of the meetings rotated on a four weekly basis, between clinical governance oversight, morbidity and mortality case presentations, divisional board meetings and meetings focusing on incidents, risks and complaints. Staff told us that meetings were attended by consultants, nurses, and managers, although junior doctor attendance was variable. They confirmed that incidents, complaints and audits were discussed at the meetings. However, we also received reports that audit meetings were sometimes cancelled by...
senior nurses and that clinical governance meetings were sometimes overtaken by management issues as reported under ‘Patient Outcomes’ section of this evidence appendix.

Minutes of meetings provided by the trust did not demonstrate a robust approach to the discussion and management of key elements of the clinical governance agenda such as management of incidents and learning from incidents, themes from complaints and actions to reduce the risk of recurrence along with lessons learned, monitoring of compliance with NICE guidance or a planned clinical audit programme. However, the divisional board agenda had standing agenda items for quality, safety, risk and patient experience, although this formed a small part of the agenda. Notes from the meetings stated themes from incidents and complaints were discussed but did include learning and dissemination of learning.

Staff were clear about their roles and responsibilities and when new roles were developed they were discussed at clinical governance meetings and job descriptions were put into place. All staff were able to attend clinical governance meetings provided they could be released from clinical commitments.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service maintained a divisional risk register, which defined the severity and priority of risks with the potential to cause harm to patients or staff. There was evidence of regular review of the risks and, in the main, actions to control and further reduce the risks were documented. The lead manager was identified. The main risks in relation to the outpatient service were related to the fabric and maintenance of the building and lack of a call bell system. We noted a call bell system had been installed in most areas and was ordered for the remaining areas. However, the risk in relation to the environment had been added to the risk register in February 2019, although the issues with the environment had existed for a much longer period. Risks were also identified in relation to imaging equipment and radiotherapy that impacted on outpatient services but are covered under other CQC core services. However, we noted that risk of imaging failure in respect of the gamma camera (a specialist scanner) had been on the risk register since 2013 and funding for a new scanner was not secured. These were all very high cost items and required a planned approach to enable replacement to be secured.

Managers were conversant with the key risks for outpatient services. They had identified an additional risk that we identified during the inspection, related to space for clinics and waiting room facilities. Although this was not on the risk register, the improvement plan for outpatient services included a proposal to increase capacity and increase waiting facilities. The funding for this had not been identified however.

Performance review meetings were held for outpatient services monthly. A performance dashboard was produced to monitor the number of outpatient attendances, cancellations and patients who did not attend their appointment. We were told the leaders for outpatient services discussed successes and challenges at the meeting and provided feedback to staff at team meetings.

The division presented a quarterly performance report for the trust finance and performance committee. This provided a summary of quality (incidents, risks, complaints and audits)
performance, cancer targets with a recovery trajectory, finance, and workforce measures. It also identified key challenges and progress against the cancer strategy. We did not see any evidence of reporting of other key indicators such as follow up to new rates or timeliness of clinics for example.

Information management

The service collected data and analysed it.

However, staff could not always obtain reliable data in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated, although they were secure.

Clinical staff and managers said there were challenges arising from poor IT systems and infrastructure. There were challenges for clinical staff in linking with other hospitals and in accessing the results of investigations. For example, they were unable to see radiological images from neighbouring hospitals and were unable to check blood results electronically. This impacted directly on patient care and created delays. Records were paper based and therefore staff were reliant on patient notes availability when they needed to speak with a patient.

In addition, managers told us they had difficulty in obtaining reliable performance data about the service at MVCC. Managers told us there were a lot of coding issues and outpatient activity was coded to other directorates, although this had improved. They also spoke about challenges in obtaining accurate staff data from the electronic staffing record system (ESR). We experienced similar difficulties in reconciling information provided by the trust, both before and during our inspection, from their electronic systems in relation to staffing, training, and annual appraisals for the outpatient service. Managers asked staff to print out the end of course certificates or print the screen shot confirming an on-line course had been completed as the system did not reliably record the completion.

A system was in place to allow patients attending for radiotherapy to check in electronically; however, this was not possible for patients attending the outpatient clinics. An electronic check in system could have potentially reduced queues at the reception desk on busy clinic days.

Engagement

Leaders and staff actively and openly engaged with patients, to obtain their views on services. They collaborated with partner organisations to help improve services for patients.

However, leaders did not always fully engage with staff, equality groups and the public, to plan and manage services.

The trust participated in the national cancer patient experience survey in 2017. From the results of the survey the trust had developed an action plan and provided a copy of this, which demonstrated the key issues for improvement were identified from the survey and action was being taken to improve. For example, patient information and clinic waiting times.

The service used the friends and family test to assess patient experience and included follow up questions to explore how patients’ experience could be improved. Staff displayed the results from the friends and family test in the department, along with patients’ comments. The recommendation result for June 2019 was 97% and data we reviewed showed this was maintained at between 95%
and 100%. Staff told us the response rates varied, as patients who came to the outpatient department frequently did not wish to complete it regularly. For this reason, questionnaires were given out on one day per week. Patients’ feedback was mostly very positive; in relation to improvements, patients identified lack of staff to attend a patient with an intravenous line and clinics running late. In response to this feedback, staff identified they were reviewing clinic templates and training more staff in the relation to intravenous lines.

During 2018 an evaluation of patient experience was completed as part of the strategic transformation programme. The service had also completed a project to explore the patients’ perspective of the effectiveness of care. Patients from two clinics (lung cancer clinic and melanoma clinic) were contacted and interviewed or asked to complete a survey. This demonstrated managers were engaging with patients to obtain their views of the service, however, we did not receive any information as to implementation of initiatives to address the issues raised and further improve the service. We were also told that some specialist nurses had completed experience surveys for their specialty.

The outpatient matron told us they had carried out sun awareness and cancer prevention sessions in a local school and there were open days for sixth formers from surrounding secondary schools, to help them understand the work carried out at MVCC and to look at possible future careers. A local school had raised funds for the provision of tablet computers for inpatients and the service supported work experience.

There was a patient advisory panel for MVCC. Members of the panel were invited to contribute to patient information publications, evaluation of services and service improvement initiatives.

Patient/carer listening events were held as part of the external strategic review, however, other evidence of engagement with patients and the public about the future direction of cancer services at MVCC over a period of time was limited.

The trust was a member of the regional cancer alliance and engaged with them to reduce variations in pathways of care; reduce inequalities of access to all aspects of care and treatment and work across boundaries.

Some medical staff expressed frustrations about the level of management engagement with them and the cancer services provided at MVCC. Staff generally spoke about the lack of investment in the service and the number of previous reviews of the service that had not resulted in change. As a result, they felt disempowered and disconnected from the rest of the trust, although they were highly committed to the cancer centre and the service they provided. The uncertainty about the future of the service had a variable impact on staff. All the staff we spoke with were positive about the recommendations of the external strategic review in relation to a tertiary provider taking over the service. A member of staff said they felt outside involvement would be valuable in implementing changes. However, until the future was determined, some staff were anxious about the level of service that would be provided and whether a tertiary provider would come forward.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Clinical staff were enthusiastic about their specialty and improving patient care. They were involved in local, national and international research studies to develop new treatments and treatment pathways. They were members of professional bodies and groups to further develop and improve standards of care. For example, a consultant was the clinical lead for development of
NICE guidance for their specialty and a clinical nurse specialist had presented at international conferences for their specialty and sat on the committee of a national association of oncology nurses.

The trust provided us with a copy of the outpatient service improvement plan. This included actions related to clinics and space, IT, nursing, pharmacy and environment. However, we noted this was not comprehensive, did not always identify target dates for completion and some issues, such as re-decoration of the environment, had been on the action plan for a year with no identified resolution on funding.

Managers had completed an audit of procedures undertaken in the procedures room in the outpatient department to inform decisions about the best utilisation of the room and resources. The number of procedures carried out in the procedures room was increasing and this had led to concerns about capacity both in the clinical areas and waiting areas. Patients appreciated the opportunity to have these procedures carried out during their appointment without having to visit other departments. Managers said there were plans to alleviate some of the pressures on capacity by relocating some of the procedures to other areas within MVCC. However, some patients we spoke with expressed concerns about the current configuration of outpatient services and the distances they had to walk, and these plans appeared to increase this. We therefore had some concerns about consultation with the public and the inclusivity of decision making in relation to these proposals.
Radiotherapy

Facts and data about this service

The Mount Vernon Cancer Centre (MVCC) treats over 5,000 new patients each year with chemotherapy and radiotherapy. A population of over two million from North West London, Hertfordshire, South Bedfordshire, South Buckinghamshire, and East Berkshire, is served with staff visiting 15 district general hospitals within this catchment area. There are 33 inpatient beds which includes specialist palliative inpatient beds.

The MVCC currently has eight linear accelerators (of which eight treat patients at any one time), two CT simulators and a cyberknife. The centre has brachytherapy equipment with active high dose rate (HDR) brachytherapy and seed implant programmes including an open bore magnetic resonance imaging (MRI) for radiotherapy planning.

Clinical research is a feature at MVCC. It is expected that all consultants should be research active, contributing both to national and international studies as well as developing their own research interests. Current areas of research activity include the development of advanced radiotherapy planning for gastrointestinal (GI) tumours, immunotherapy for renal cancer and melanoma, novel radiotherapy techniques for prostate cancer and functional imaging for assessing response to chemotherapy and radiotherapy.

(Source: Routine Provider Information Request AC1 - Acute context)

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 made sure everyone completed it.

Mandatory training completion rates
Staff received and kept up-to-date with their mandatory training.

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

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>6</td>
</tr>
</tbody>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL
In radiotherapy the 90% target was met for seven of the eight mandatory training modules for which registered nurses were eligible. Care should be taken when interpreting training rates due to a low number of registered nurses in this service.

The trust did not report any medical staff working in radiotherapy at the trust.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for allied health professionals in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality &amp; Diversity</td>
<td>70</td>
<td>74</td>
<td>94.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>63</td>
<td>67</td>
<td>94.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>69</td>
<td>74</td>
<td>93.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>69</td>
<td>74</td>
<td>93.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>69</td>
<td>74</td>
<td>93.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>61</td>
<td>67</td>
<td>91.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>67</td>
<td>74</td>
<td>90.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Non-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>61</td>
<td>74</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In radiotherapy the 90% target was met for seven of the nine mandatory training modules for which allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
We requested the training rates for clinical staff trained in basic life support. The service had 85% of relevant staff trained which fell slightly below the 90% target. The service informed us that all remaining staff were booked on a training course to ensure compliance.

The mandatory training was comprehensive and met the needs of patients and staff. The service’s training was provided as both online learning and face to face sessions.

Staff had access to training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff told us that training on mental health, learning disabilities, autism and dementia was included in the Mental Capacity Act (2005) and adult safeguarding training. Staff had access to training on dementia, but this was not mandatory. The trust had recently introduced training on learning disabilities.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training was monitored electronically, and staff received reminders to complete training. Clinicians had to ensure their mandatory training was complete as a requirement to pass their appraisal.

**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.

Staff received training specific for their role on how to recognise and report abuse. Staff received online training on safeguarding which allowed them to complete the training at a time that was convenient to them.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training. This was met for both Nursing and allied health professional staff.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td></td>
<td>staff</td>
<td>staff</td>
<td>rate</td>
<td>target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In radiotherapy the 90% target was met for all four safeguarding training modules for which qualified nursing staff were eligible. Care should be taken when interpreting training rates due to a low number of qualified nursing staff in this service.
The trust did not report any medical staff working in radiotherapy at the trust.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for allied health professionals in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>51</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>69</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>61</td>
</tr>
</tbody>
</table>

In radiotherapy the 90% target was met for all four safeguarding training modules for which allied health professionals were eligible.

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

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could give examples of the types of abuse that would constitute a safeguarding concern and examples of abuse that they had referred, including when a vulnerable patient told a member of staff that people were coming into their room at night at their residential home when they shouldn’t be. Staff told us they would contact the trust’s safeguarding lead or the service’s accessibility coordinators if they needed advice.

We observed that staff followed good practice to identify that the correct patients were being treated. The service used the three points of identification check (name, address and date of birth). We observed that the staff consistently followed this process. The treatment software allowed the patient’s photograph to be uploaded onto the system. This gave an additional check on top of the mandatory patient verbal identification check.

The service had an effective process for reviewing potential clinical harm to patients. The cancer service held quarterly clinical harm meetings led by the service’s divisional chair and divisional clinical director to review any cases of potential harm caused by breaches. We reviewed the minutes of these meetings and saw that breaches were reviewed, conclusions drawn and actions assigned, where harm was identified.

**Cleanliness, infection control and hygiene**

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment
and the premises visibly clean. However, the service had poor results in their hand hygiene audits and did not keep a log to demonstrate when equipment had been cleaned.

We requested the service’s hand hygiene audits for the previous 12 months but were only provided with audit data for July and August 2019 due to the implementation of a new audit tool. The service had scored poorly in the July 2019 hand hygiene audit, with a compliance rate of 40%. The service introduced new hand hygiene training to try and improve results, there had been a slight improvement in August 2019 with a compliance rate of 75%.

Staff cleaned equipment after each patient contact but did not always record the cleaning of equipment to show when it was last cleaned. The service’s radiographers cleaned the linear accelerators weekly but did not keep a log of what they had cleaned and when. This meant that the service could not evidence that there was regular cleaning of equipment. We raised this as a concern with the leadership team who informed us that in the future, that a log was kept.

Areas were clean and had suitable furnishings which were clean and well-maintained. Domestic services within the trust audited the cleanliness of the service monthly. The audits were sent to the service leads who would action any concerns or results that fell below the 95% target. We saw that the service’s cleaning audits were 98% for June 2019 and 99% for May 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff sanitising their hands appropriately. Staff were bare below the elbows in line with the trust’s policy.

The service did not have any hospital acquired infections within radiotherapy from August 2018 to August 2019.

**Environment and equipment**

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. This was carried out by radiographers at 7am each morning. The process involved bringing the linear accelerators up to operational readiness and undertaking quality assurance checks. Therapeutic radiographers received training from the physics service to undertake this task.

We observed that the service had clear documentation in place which outlined which staff groups were responsible for the machines. The medical physics experts (MPE’s) were responsible for conducting monthly checks on the linear accelerators. The service had recently implemented electronic data trending which allowed the MPE’s to see where a machines output is beginning to rise and allowed them to adjust accordingly.

A resuscitation trolley with emergency equipment was available in the department. The trolley had a defibrillator, suction machine and portable oxygen cylinders. Equipment was mostly checked and recorded daily. However, we saw that in April 2019 and June 2019 there were three weekdays in which the trolley had not been checked.

We checked fifteen pieces of consumable equipment including airways, bandages and tubing, all of which was in date.
The service had suitable facilities to meet the needs of patients’ families. We saw that the department had a wide range of equipment available for use and this included some of the latest radiotherapy equipment available. The area where the linear accelerators were situated had their own changing and waiting rooms, with enough seats for relatives to sit and wait with each patient.

The department operated a paper-free system where all data was held on the computer system. This reduced clutter and kept the work environment clear. It also eliminated the risk of mixing papers and instructions.

There was a clear maintenance plan for the radiotherapy equipment which detailed when equipment was due to be serviced and quality assessed. We saw evidence that equipment was being serviced in accordance with manufacturer's instructions and timescales.

The service had enough suitable equipment to help them to safely care for patients. The service ran six out of their eight linear accelerators at any one time ensuring they had spare machines to allow for servicing and break downs.

Staff disposed of clinical waste safely. There were appropriate arrangements in place to send equipment from the cyberknife unit to be sterilised.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Staff used control measures to ensure that the right treatment dose was applied to each patient and monitored patients appropriately throughout treatment.

Staff responded promptly to any sudden deterioration in a patient’s health. Staff provided an example of where they dealt swiftly with a patient who experienced a cardiac arrest within the unit. Staff had called the trust’s arrest team and had done so promptly and commenced CPR whilst waiting for them. All staff we spoke with were aware of what to do in emergency situations.

The service ran a radiographer led review service. Radiographers would telephone patients two weeks after they had started their treatment to ensure patients were satisfied with their experience and to ask them about their side effects. We observed staff asking patients how they were feeling at the start of each appointment and enquiring about side effects.

The service followed up patients through a telephone appointment, which they were given at their final treatment. The time-period for this call to varied for each specialty. For example, patients with head and neck cancers, were followed up after one week and those with breast cancer were followed up after six weeks.

Patients were reviewed daily by the radiographer treating them, as part of the treatment process. This allowed the treatment team to assess changes in the patient’s condition on a daily basis.

We observed that staff followed standard procedures to identify that the correct patients were being treated. The treatment software allowed the patient’s photograph to be uploaded onto the system. This gave an additional check on top of the mandatory patient verbal identification check (name, address and date of birth,) that were always undertaken. We noted that the staff always followed this process.

We saw that there were local rules and employers’ procedures in place which protected patients and staff from ionising radiation. The service had measures in place to protect staff and patients from radiation. These included interlocking doors and lights that warned that radioactive activity was taking place during treatment. Bi-annual radiation protection committee meetings were held.
where the local rules, radiation incidents and reports from each area involving staff dose incidents and environmental monitoring results were discussed.

Patients were reviewed weekly by their consultant at specialist multi-disciplinary team (MDT) meetings. For example, the head and neck MDT met weekly to review images.

Patients were treated by two radiographers. One radiographer was responsible for initiating the treatment and the other for monitoring the patient through the camera and intercom system. We saw that the radiographers performed checks on the patient’s identity, treatment site and dose prior to commencing treatment.

Radiographers completed weekly checks for each patient. The checklist included cancelled appointments, correct doses, diodes approved, operator signature in records, imaging complete and additional appointments booked in. We observed that there was a good overview of patient toxicities, this was completed on a weekly basis and added to the record system. Staff checked that patients’ images and toxicity levels had been completed for those who were attending the next day.

The service had a process in place to ensure that pregnant or breastfeeding women did not receive treatment. The patient’s pregnancy status was confirmed prior to their first treatment and signed off by the treating consultant. However, there were no signs in the treatment room to prompt pregnant or breastfeeding women to alert staff of their status should this have changed since their consultation.

There were daily huddles in place to hand over patients and discuss any concerns that they may have.

**Staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

**Trust level**

The table below shows a summary of the nursing staffing metrics in radiotherapy at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>118</td>
<td>-7%</td>
<td>11%</td>
<td>3.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>6</td>
<td>17%</td>
<td>20%</td>
<td>1.0%</td>
<td>489</td>
<td>0</td>
<td>763</td>
</tr>
</tbody>
</table>
The service was at the time of our inspection at establishment for allied health professionals.

**Medical staffing**

The trust did not report any medical staff working in radiotherapy at the trust.

**Allied Health Professional staffing**

**Trust level**

The table below shows a summary of staffing metrics for allied health professionals in radiotherapy at trust level compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>118</td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>All Staff</td>
<td>64</td>
<td>-7%</td>
<td>11%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>64</td>
<td>-7%</td>
<td>13%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Allied health professional staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

**Vacancy rates**

Monthly vacancy rates over the last 12 months for allied health professionals showed a shift from October 2018 to March 2019. However, at the time of our inspection senior leaders told us that the service was at capacity for allied health professionals following a recent recruitment.
exercise.

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

Staffing levels were frequently assessed at the services management meetings, called superintendent meetings. Weekly forecasting, service demands, and rotas were considered, to ensure there were correct staffing levels and skill mix for the week ahead.

The service had implemented new flexible working shifts for radiographers which leaders told us had improved retention and sickness rates. The service ensured that each day four radiographers were allocated to each linear accelerator machine. We saw that at least two radiographers monitored patients at any given point whilst the other radiographers conducted patient reviews. The service ensured a good skill mix of radiographers were allocated to each linear accelerator, ensuring that two senior radiographers were paired with two more junior radiographers.

The radiographers were supported by two senior radiographers, superintendents, who were not allocated to linear accelerators but worked across the department supporting the teams. Leaders told us that they had not used bank or agency staff for two years because they had a full complement of staff. In the event of staff shortages, one of the senior radiographers or medical physical experts would work clinically to cover a shift. Leaders told us that this arrangement worked well because it allowed senior members of staff to maintain their competencies and work clinically from time to time. Radiotherapy staff we spoke with told us that they were happy with the staffing levels in the service.

The service had an on-call provision for medical physics experts and radiographers. Staff in radiotherapy told us that they could access clinical nurse specialists if they required their input.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed ten sets of records and saw that they were up to date, comprehensive and contained all the necessary information to treat the patient, according to the agreed plan.

Records were stored securely. The service had implemented an electronic records system two and a half years prior to our inspection and were completely paperless. There was a dedicated radiotherapy IT team who were responsible for ensuring that the systems were running adequately. They addressed any faults, if they arose.

When patients were discharged, all the information needed for their ongoing care was shared appropriately in a timely way with the patient’s GP and referring surgeon. The service’s software generated and sent a discharge letter following the completion of the patient’s radiotherapy treatment.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.
Staff stored and managed medicines in line with the provider’s policy. We saw that emergency medicines were stored in the resuscitation trolley in sealed boxes detailing the expiry dates for medicines. All medicines we viewed were within their expiry date.

The service had three Patient Group Directives (PGD) in place for contrast for CT scans, sodium chloride and micro-enemas. There was a staff competency for each PGD. We saw that the PGD’s were in date and only used at the Mount Vernon site.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

**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 June 2018 to May 2019, the trust reported no incidents that were classified as a never event for radiotherapy.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in radiotherapy, which met the reporting criteria set by NHS England, from June 2018 to May 2019.

*(Source: Strategic Executive Information System (STEIS))*

Staff knew what incidents to report and how to report them. The service used an electronic data reporting system. Staff we spoke with gave examples of incidents they had reported including machine failures.

The service reported incidents as required following the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R.) We were confident that staff had a good understanding of the incidents that required reporting and that they engaged well with the CQC IR(ME)R inspectors when necessary.

Staff understood the duty of candour. All staff that we spoke with could provide us with an explanation of the duty of candour and examples of incidents that the duty should be complied with. They were open and transparent and gave patients and families a full explanation if and when things went wrong.
Managers investigated incidents thoroughly. The service scored the incidents using national guidance, ‘Towards Safer Radiotherapy.’ The service’s radiotherapy manager and quality assurance manager had oversight of incidents within the unit. Managers worked alongside different departments to code incidents, investigate them and share any learning through the services service line report presented at performance meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback about incidents at team meetings and staff told us that the service leads held training sessions on specific incidents such as imaging errors.

There was evidence that changes had been made as a result of feedback. Staff we spoke with gave examples of incidents they had reported and changes made as a result. One example was two incidents where radiotherapy had not been applied to the correct site (geographical miss) for a patient with breast cancer. As a result, a new policy of daily imaging for breast boost patients was implemented to prevent wrong positioning of the linear accelerators.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and made it publicly available.

Safety performance was continually monitored. Incident themes and trends were displayed, along with the service’s risks and challenges, on notice boards outside the main reception area.

### Is the service effective?

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Treatment protocols had been established, which followed national guidance. These were audited every six months. All staff we spoke with knew how to access the protocols and we observed that they followed them consistently.

The radiotherapy service operated a radiotherapy quality system which was accredited to the ISO 9001:2008 quality standard. This ensured that all procedures that the department undertook were all documented. All procedures had a work instruction that detailed the task required.

All new staff were required to read the quality system to understand the tasks and how they were undertaken at Mount Vernon Cancer Centre. The quality system was audited regularly, and this was checked as part of the accreditation process.

The service’s clinical lead told us that a peer review process had been implemented for all patients. All patients’ treatment plans were reviewed by another consultant to ensure that treatment provided was in line with evidence-based practice.

Clinicians told us they were expected to attend royal colleges’ conferences relating to the different sites that they were treating. For example, the head and neck association. Clinicians told us that
these conferences provided them with information on the latest evidence-based care and treatments.

The service’s Medical Physics Experts performed monthly checks on equipment in line with the Institute of Physics and Engineering in Medicine guidance.

The service offered Intensity Modulated Radiotherapy (IMRT) according to the ‘gold standard’ recommendations of the NHS commissioning clinical reference group. IMRT allows the intensity of the radiotherapy plan to tailored to the size, shape and other dimensions of the tumour. This reduces the amount of normal healthy tissue included in the treatment area. This has two benefits, firstly a reduction in the side effects from treatment. Secondly, it allows the potential for a higher dose of radiotherapy to be given if this is deemed beneficial.

The National Cancer Action Team identified that at least 24% of patients should be offered radiotherapy using IMRT. The service exceeded this target by achieving an average of 40% IMRT delivery.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were aware of the requirements of the MCA and told us they would seek advice from the service’s accessibility coordinators if they had a patient they were concerned about.

Staff were aware of the psychological and emotional needs of patients, their relatives and carers. Staff could also refer patients to the Lynda Jackson centre within MVCC. Patients could access information and support about all aspects of their cancer care and treatment, including emotional support. The service offered a timetable of activities for patients and carers including relaxation sessions.

The radiotherapy service was accredited to the ISO 9001 quality standard.

Nutrition and hydration

**Patients had appropriate access to food and drink.**

The service had access to a nutrition and dietic team with specialist oncology dieticians. Staff we spoke with were aware how to refer to this service.

There was access to drink and food in the main waiting area.

Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain.**

Patients requiring a clinical review for their pain were seen by the medical staff. We saw that staff knew the procedure to access a medical review.

Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.**
Managers carried out a comprehensive audit programme. The programme included audits on IR(ME)R procedures, patient consent, radiographer checklists, reviews of specific patient sets, scanning with IV contrast and audits into specific treatment plans for different sites.

Managers used information from the audits to improve care and treatment. The service had a standardised clinical audit project outcome form which staff were expected to complete. The forms detailed where the learning from the audits was shared and how actions would be completed. We reviewed three audit project outcome forms and saw that learning was identified and comprehensive action plans were put in place where improvements could be made. Actions were assigned to specific members of staff with a deadline for implementation alongside a risk assessment.

Managers shared and made sure staff understood information from the audits. Staff told us that audit results were fed back at band-specific team meetings and performance review meetings.

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. Current clinical trials included but were not limited to:

- The Institute of Cancer Research’s RAIDER trial in adaptive image guided radiotherapy in bladder cancer;
- Cancer Research’s PIVITOL boost trial which considered whether having radiotherapy to the lymph nodes in the pelvic area as well as the prostate, improved treatment for prostate cancer;
- POSNOC trial that considered treatments such as chemotherapy and hormone therapy to target breast cancer, that had spread to the axilla without the need for further treatment directly to that area.

The service had a research radiographer who was responsible for coordinating the trials.

The centre had projects ongoing in the medical physics department to improve patient outcomes. This included projects to consider artificial hips and radiotherapy planning.

**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 and development.

**Appraisal rates**

From April 2018 to March 2019, 92.2% of staff within radiotherapy at the trust received an appraisal compared to a trust target of 90%. The trust target was met by all staff groups other than healthcare scientists. However, the appraisal rate for this staff group was close to target with a completion rate of 87.1%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an</td>
</tr>
<tr>
<td></td>
<td>Eligible staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL Page 387
<table>
<thead>
<tr>
<th>Count</th>
<th>Appraisal</th>
<th>Pass 90%</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>56</td>
<td>60</td>
<td>93.3%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>27</td>
<td>31</td>
<td>87.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106</strong></td>
<td><strong>115</strong></td>
<td><strong>92.2%</strong></td>
</tr>
</tbody>
</table>

Note: The trust did not report any medical staff working in radiotherapy at the trust.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had structured programmes in place to ensure that staff were taught competencies and assessed appropriately. We saw that the clinical educators updated records when staff had been signed off for their various competencies. These were accessible for all radiotherapy staff to view on the radiotherapy intranet.

Managers gave all new staff a full induction tailored to their role before they started work. New staff had a three week induction period in which involved rotating into different departments to ensure their preliminary competencies were completed. Staff we spoke with told us that they felt supported on induction and that managers had regularly checked in on them.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us that they found their annual appraisals meaningful and that they set out their goals for the year ahead, discussed any continuing professional development that they wished to complete and created a development plan for the year ahead.

There were enough clinical educators to support staff learning and development. The service had two clinical learning facilitators who assisted radiographers with their competencies and additional learning. All staff we spoke with could name the educators and spoke about additional training sessions the educators had held, including clinical supervision sessions and peer support groups.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings were held during staff’s lunch break and staff were given the time back, to ensure attendance levels were high.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they were encouraged to develop and were given time off for continuing professional development. There was a number of training programmes to upskill and develop staff including the scientist training programme for medical physicists and the higher scientist in radiotherapy specialist programme, that was training for medical physicists to become consultant clinical scientists.
We spoke with student radiographers who told us that the service was an excellent training placement because the staff were enthusiastic about training students and gave high levels of support. All students were provided with a mentor who discussed their objectives with them. Additionally, formalised ‘catch ups’ were in place, to ensure students were happy and on course to meet their objectives.

Managers made sure staff received any specialist training for their role. The radiotherapy leaders provided weekly training sessions to help staff achieve their competencies. The service’s clinical learning facilitator monitored that staff had completed competencies.

Managers identified poor staff performance promptly and supported staff to improve. Service leaders told us that poor practice was identified through the competency framework and that extra support was given to staff who were struggling with their competencies. In the event of continuing poor performance service leads performance managed staff. The service’s practice educators and superintendents (senior radiographers) offered coaching to staff who were struggling with their competencies.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers we spoke with told us that they had received adequate training for their role and felt well supported by leaders within the service.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However medical staff were not always working effectively to ensure their input at MDT meetings.*

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. However, very few multi-disciplinary team (MDT) meetings were chaired and coordinated by the consultant oncologists at MVCC and the overall responsibility for the patient pathway remained with the referring hospital. Medical staff supported formal multidisciplinary meetings in surrounding trusts, providing specialist oncology representation to these meetings. However, medical staff told us that they were not always able to attend these meetings in person and therefore their specialist advice was not always readily available. Attendance at MDT meetings was not tracked and therefore the service’s clinical lead was unable to tell us how many MDTs were being missed.

The oncology service had implemented weekly patient tracking list meetings and ensured that a representative from each clinical area attended, so the list of patients was reviewed by the whole oncology service. This ensured the teams were working together to prevent any delays. Service leads told us that the multi-disciplinary team reviewed the patient tracking list daily, cases were discussed, and actions implemented for any breaches at the service’s clinical harm meeting.

Staff worked across health care disciplines and with other agencies when required to care for patients. All staff we spoke with told us that radiographers and medical physicists worked closely together and the relationship between the disciplines was helped with secondments for radiographers into the radiotherapy planning department, where they worked alongside each other. Staff across the hospital and the multidisciplinary team in the hospital worked together for the benefit of the patient. This included contacting outside agencies, for example if a patient required assistance in the community.
Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There were effective pathways in place for referral to mental health services. The trust had a referral number and the services accessibility coordinators were available to assist with referrals where staff needed help.

**Seven-day services**

*Key services were available seven days a week to support timely patient care.*

The service operated from 8am until 10pm from Monday to Friday.

The service had an on-call service that operated over the weekends for emergency radiotherapy.

**Health promotion**

*Staff gave patients practical support and advice to lead healthier lives.*

The service had relevant information promoting healthy lifestyles and support in the corridors of the cancer centre. We saw posters promoting the trust’s Macmillan health and wellbeing event throughout the service. There were also posters advertising a ‘healthy balance clinic’ which was held at the cancer centre and looked to provide safe and sustainable weight loss whilst improving energy levels.

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

*Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.*

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

**Trust level**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training was delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at trust level for qualified nursing staff in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>6</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>6</td>
</tr>
</tbody>
</table>

In radiotherapy the target was met for both MCA/DOLS training modules for which qualified nursing staff were eligible.

The trust did not report any medical staff working in radiotherapy at the trust.
A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for allied health professionals in radiotherapy is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>68</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>61</td>
</tr>
</tbody>
</table>

In radiotherapy the target was met for both MCA/DOLS training modules for which allied health professionals were eligible.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the MCA. Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. The service had accessibility coordinators who received additional training on the MCA and DoLS and were a point of contact for staff, if they needed any advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and clearly recorded consent in the patients’ records. We saw that this was clearly documented in the ten patient records we reviewed. Staff made sure patients consented to treatment based on all the information available.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff told us that clinicians made decisions in their best interest, taking into account patients’ wishes, culture and traditions. The service’s access coordinators delivered sessions on DOLS and the MCA using real-life case studies from within the department.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff speaking respectfully to patients, engaging them in polite conversation and making jokes to try and ensure patients felt at ease before their treatment.

Patients said staff treated them well and with kindness. All patients we spoke with told us that staff were kind and that they could not fault the staff in the service. One patient told us that the staff, “always introduce themselves and treat me with respect. They are friendly and open”.

Staff followed policy to keep patient care and treatment confidential. Staff ensured that they only discussed patients when doors were shut, or patients and their relatives were not in earshot.
Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff being compassionate and understanding of a patient who had anxiety about their treatment, by allowing extra time for their appointment to ensure they were comfortable. Additionally, they asked the patient throughout their time in the department, if they were comfortable.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing reassurance to patients undergoing treatments, particularly those who had to be placed in uncomfortable positions or had to use face masks as part of their treatment. Staff were encouraging, checked the patients were ready for the masks to be fitted and tried to ensure all patients were as comfortable as possible.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. We observed staff reassuring distressed patients and allowing them extra time to adjust. Staff gave examples of when patients had become distressed and they had called staff from the Lynda Jackson Centre over to provide some relaxation techniques to assist the patients. One patient who had been anxious about their treatment told us they, “have found the staff to be empathetic, reassuring and I can’t fault them”.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them and demonstrated empathy when having difficult conversations. All staff that we spoke with were sensitive to the needs of patients, particularly those with anxieties around treatment and demonstrated a genuine desire to ensure patients had the best experience possible whilst in their care.

Patients and their relatives had access to the Lynda Jackson centre where staff were trained in supportive listening to provide emotional support and information. The service had access to trained counsellors and complimentary therapies to support patient’s wellbeing.

The Lynda Jackson centre ran a number of support groups that patients could access such as the Asian Women’s Cancer Group, the Prostate Cancer Support Group and a pre-radiotherapy support group for women with breast cancer.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with told us that they were clear about their treatment plan and the information they had been provided by the service. Patient’s told us that staff had given them the opportunity to ask questions and staff discussed their treatment in a way in which they could easily understand.

Staff talked with patients, families and carers in a way they could understand. Patients told us their families had been involved with their appointments and felt comfortable asking questions.
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. From June 2018 to June 2019 an average of 93.4% of patients would recommend radiotherapy outpatients.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service ensured they offered patients choice and flexibility when arranging appointments. Booking coordinators asked patients what appointment times would suit them for their radiotherapy and whether they had any special requirements. We viewed four completed booking forms that demonstrated a choice of appointments had been offered to the patients.

The service had increased opening hours since our last inspection. The service previously operated from 8am until 8pm but they had extended their operating times until 10pm to meet an increase in demand.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had two accessibility coordinators whose role was to ensure patients with any additional needs were supported to access the service. The coordinators identified patients with additional needs at the time of booking, assisted with transport arrangements and attended the patient’s first appointment with them, to provide them with reassurance and to orientate the patient to the unit. If a patient required ongoing support the coordinators would arrange for a volunteer to attend the patient’s appointments with them.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff we spoke with were aware of who to contact should they require mental health support.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. The service’s electronic system flagged when a patient had not attended an appointment and automatically triggered a new appointment to be created when a patient did not arrive for their appointment. Staff told us that the service’s booking facilitators and accessibility coordinators contacted the patient immediately and made an alternative appointment as soon as possible.

The service had safeguards in place to ensure that patient’s missed appointments were actioned. Cancelled appointments were an item on the service’s weekly checklist for every patient. Staff checked that all appointments were attended and that alternative appointments were booked in the event of a cancellation, or a did not attend.
Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, clinical staff had not been trained in dementia care.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service’s accessibility coordinators coordinated care for people with disabilities and sensory losses. They met the patient at their first appointment and attended the appointment, if the patient wished to be accompanied. Additionally, they arranged ongoing support from volunteers. The accessibility coordinators had access to communication tools for patients with sensory loss, for example, picture boards.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. However, clinical staff had not been trained in dementia care. All staff we spoke with were aware of the accessibility coordinators and how to contact them for help if they had patients with any individual needs that had not previously been identified. However, only the service’s accessibility coordinators had received any training on dementia. The service’s matron was coordinating additional training for the broader establishment, but this was not in place at the time of our inspection.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service’s accessibility coordinators updated the electronic records system with regards to patient’s needs, to ensure that all staff were aware of any individual who may need assistance. Staff we spoke with were aware of how to find this information with regards to patients’ needs and told us they always checked this prior to treatment.

The service’s accessibility coordinators attended accessibility meetings at the trust’s main site to ensure they were meeting the needs of patients and to keep up to date with any developments in the sector.

The accessibility coordinators were assisted by a team of 15 volunteers who would buddy with patients with individual needs such as patients living with dementia and assist with their hospital appointment. This included helping with prescriptions at the pharmacy and checking the patients out and onto their transport.

The service had information leaflets available in languages spoken by the patients and local community. The service had a vast range of information leaflets throughout the Mount Vernon site and in the Lynda Jackson Centre. Leaflets included tumour types, managing treatment side effects, getting to the hospital, skincare following radiotherapy and bereavement.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed.
Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (radiotherapy)

The trust had met the 94% operational standard for patients waiting less than 31 days before receiving their first radiotherapy treatment following a diagnosis (decision to treat) from July 2018 to April 2019. The performance over time is shown in the graph below.

% Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (radiotherapy), East and North Hertfordshire NHS Trust

(Source: NHS England – Cancer Waits)

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service leads told us that they had made a number of changes, to improve cancer wait times and bring them in line with national standards. One project identified, where there were delays in some pathways, including delays caused by patients waiting for fiducial markers (an object placed within the field of view as a point of reference or measure) to be inserted by clinicians. In response a pilot scheme had been implemented where radiographers were trained to put fiducial markers in patients with prostate cancer.

Referrals for radiotherapy were sent electronically and categorised in terms of scheduling urgency, to ensure that patients who needed to be seen swiftly could be.

There was a team of administrative staff for scheduling and booking appointments. The team booked all parts of the pathway (including patients having radiotherapy and chemotherapy at the same time).

The service had pilot schemes in place to improve access. This included a head and neck rapid access pilot scheme. All patients who were deemed to be a category one patient, (most urgent) underwent a new pathway where the service had worked to ensure quicker access to CT
scanning. This had reduced the referral to treatment time for this set of patients from 50 to 17 days.

Patients using the service could check in using a self-service machine in the reception area to avoid waiting in line for the cancer centres reception.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had recognised from their data that there was often a delay caused when a patient was receiving chemotherapy and radiotherapy in the same day. In order to reduce this delay, the service employed a chemotherapy-liaison radiotherapy assistant. The chemotherapy liaison assistant was responsible for ensuring that the patient received both aspects of their treatment on time.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

**Summary of complaints**

**Trust level**

From April 2018 to March 2019, the trust did not receive any complaints specific to radiotherapy.

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

**Number of compliments made to the trust**

From April 2018 to March 2019 there was one compliment about radiotherapy at Mount Vernon Cancer Centre.

The trust stated that compliments were received through the CEO’s office, these were responded to and sent to the relevant areas by the CEO. They were then shared with the complaints team for recording.

The trust also stated that they receive multiple compliments through both their social media platforms and directly to areas across the trust. The trust was developing a consistent approach on how to capture, record and share themes and trends that related to compliments and praise.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives we spoke with, said they would raise concerns with staff in the department, through patient feedback forms or through the Patient Advice and Liaison Service (PALS). The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us that the complaints procedure was on the service’s intranet and they knew how to access leaflets to give to patients should they wish to raise a formal complaint.
Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The services quality assurance manager and head of nursing oversaw complaints. The service had not recently received any complaints, but staff could give examples of shared learning from previous complaints. They gave an example of a complaint raised by a patient who had raised concerns with the way the radiographer communicated with them. Leaders within the service used it as a case study at a team meeting to ensure that learning about communication was shared with all staff.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience necessary for their roles. The service was led by a head of radiotherapy physics, a head of radiotherapy and a clinical lead for radiotherapy.

Leaders we spoke with understood the challenges to quality and sustainability and could identify actions needed to address them. This included the replacement of old machinery and updating hardware on machines, to ensure that they were compatible with the latest software available. The service leaders told us that the replacement of equipment was challenging because there was uncertainty over the future direction and configuration of services with the current provider. Other challenges included ensuring that the service continued to meet their referral to treatment targets and to ensure they maintained staffing levels.

Staff told us that leaders at all levels were visible and approachable. Staff felt supported by their managers and had regular one to ones and annual appraisals. The cancer service’s staff survey had identified that leaders were not always visible in the organisation. In response to this the services director for cancer had set up monthly briefing sessions for staff and monthly office hours. Staff we spoke with told us that there had been an improvement in the visibility of leaders since our last inspection.

Leadership development programmes were in place to ensure sustainable, compassionate, inclusive and effective leadership. Senior leaders we spoke with had completed leadership training within the trust. The trust additionally conducted quarterly leadership training sessions that all staff were invited to attend.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a Mount Vernon Cancer Centre (MVCC) clinical strategy for 2018 to 2022 with four key aims:
- To deliver high quality, safe, efficient and innovative services
- With partners transform how cancer care is provided
- Harness patient views and technology to transform the environment in which we deliver care
- Attract and retain high quality, expert staff supported by a culture to learn and thrive.

A clinical strategy delivery group monitored progress through an action plan to deliver these aims. MVCC had produced strategic highlight reports for each strategic objective, reporting on progress, outstanding actions and actions.

The external strategic review of cancer services at MVCC which took place in June 2019 had resulted in recommendations which provided two preferred options for the future direction and configuration of services. The trust had worked with key stakeholders to progress the recommendations of the strategic review and implement the preferred options. They had developed a draft action plan, with key steps towards implementation of the recommendations.

Service leaders told us that they had created the strategy to align with the national cancer strategy, to ensure that the service met changing targets and that waiting times were reduced.

The service was working effectively in their cancer alliance radiotherapy network. They had recently joined a new network, to better reflect their geographical location. The service had undertaken a gap analysis to ensure that it met the metrics of the network. They were aware of the alliance’s aims, which included standardising protocols and providing greater access to trials.

**Culture**

*Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.*

There were high levels of satisfaction across all staff including those with protected characteristics under the Equality Act. All staff we spoke with were positive about the culture of the service and staff were immensely proud to work there. Staff we spoke with were keen to show us their work and were highly motivated to explain the service’s protocols.

Leaders we spoke with had a shared vision and knew how to inspire and motivate staff to achieve this vision. All staff were committed to providing excellent care to patients using their services and ensuring that patients were seen promptly.

Staff told us that the managers were supportive and ensured staff were treated with respect. Every member of staff we spoke with told us that their manager was supportive and encouraged them to access development opportunities available within the trust.

Staff at all levels were encouraged to speak up and raise concerns at team meetings which were orchestrated to be band specific, so staff could talk about any concerns that affected their particular roles and ensured feedback was relevant. We observed that freedom to speak up guardian posters, were displayed in corridors and most of the staff we spoke with were aware of the freedom to speak up service and how to access it.

There was strong collaboration, team-working and support across all functions. Staff in every area had a common focus on improving the quality and sustainability of care and people’s experiences. The medical physics expert team were engaged in multiple projects to improve care and quality
within the service and were passionate about ensuring that the results of which had a positive impact on patients experience and outcomes.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure that allowed concerns, risks and performance data to be fed up to the divisional board.

Staff were provided with regular opportunities to meet and raise any concerns they may have had. The service held bi-monthly band-specific meetings which were chaired by senior leaders, in addition to monthly overall staff meetings. Meetings were held in staff’s lunch break and staff were given the time back as an incentive to improve attendance. Staff we spoke with told us that these meetings were well attended and provided them with an opportunity to raise any concerns and to hear about the performance of the service. We reviewed the minutes of these meetings and saw that feedback from incidents, trust strategy, risk registers, audit feedback, trials, workforce, capacity, patient care group feedback and competencies, all were discussed as standing agenda items.

The band and team meetings fed into the monthly management meetings attended by the service’s superintendents. We reviewed the meeting minutes and saw that leaders discussed patient tracking, capacity, audits, risks, incidents and network updates.

The service had site-specific (e.g. breast, lung, head and neck) Quality Improvement Team (QIT) meetings every three months. The meetings discussed developments in research, trials, audits, competencies, guidelines, feedback from staff and service improvements. The site-specific QIT meetings fed into the quarterly radiotherapy QIT meeting. We saw that workforce, the latest staff survey, legislation updates and capital equipment, were items that were discussed.

The service held monthly radiotherapy performance review meetings. These fed into the quarterly radiotherapy QIT meetings and the service’s weekly clinical governance meetings. We saw that there was an agenda item, to raise any actions from staff and manager meetings.

Both the radiotherapy QIT meeting and clinical governance meeting fed into the Cancer Services Divisional Board Meeting. We saw that workforce, estates and facilities, quality, risk, patient experience, operational performance, training and education, complaints, strategy and successes and challenges for each department, were discussed.

Clinicians held weekly clinical governance meetings. We saw that these discussed the services strategy, operational issues, recruitment and medical training.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was a risk register in place, that detailed risks, actions to mitigate, a risk level, an owner and a review date. There were 37 risks on the Mount Vernon Cancer Centre (MVCC) division risk
register, of which three related to radiotherapy. These risks involved equipment failure and possible fire risks. Leaders were aware of the risks that featured on the register.

Risks were entered on the electronic system by the governance team to ensure they had full oversight of them. Individual risks were owned by senior staff and those that we reviewed had been managed effectively. Potential risks were discussed and agreed at the divisional performance review meetings before they were put on the register. We saw that radiotherapy risks were also discussed at the service’s superintendent meetings. Leaders told us that risks were raised informally by speaking with the lead, or by raising the risk through staff meetings.

Operational issues were reviewed monthly at the performance review meetings. We saw from the minutes that there were reports on challenges, successes, risks, quality and safety - including incident trends, friends and family test performance, audit completion, cancer waits, activity, actions from governance meetings, progress against strategic aims and workforce.

Mortality and morbidity meetings were undertaken monthly as part of the MVCC governance structure and the service was expected to feed into the trust wide mortality and morbidity meetings. However, we reviewed meeting minutes for December 2018, February 2019 and April 2019 and there was no representation from MVCC.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There were arrangements in place to ensure that data protection standards were adhered to. We observed that staff did not send the next patient in to be seen until the previous patient’s information had been cleared from screens.

There were clear and robust performance measures in place including cancer waits and results from the friends and family test.

Staff could access performance data in an easily accessible format through the service’s performance review meeting presentations, which tracked performance of cancer waits and incident trends over time.

Notifications were consistently submitted to external organisations as required in relation to the Ionising Radiation (Medical Exposure) Regulations 2000.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service held bi-monthly patient experience meetings which discussed ways in which the patient experience could be improved, examples of which included equipment availability in the room, transport, patient appointments, any concerns raised on the incident reporting system relating to patient experience and accessibility. However, the feedback into the meeting was all from staff and there were no patient representatives in the group.
The service collected feedback and compliments from patients and shared these as part of their quality, safety, risk and patient experience reports that went to the divisional board.

The trust participated in the national cancer patient experience survey in 2017. From the results of the survey the trust had developed an action plan which demonstrated the key issues for improvement and associated actions.

Staff told us that they felt able to raise concerns and ideas in the service’s monthly team meetings.

We saw that the cancer service had performed well in the 2018 staff survey for equality and diversity and providing a safe environment. However, the service had scored lower than the rest of the organisation for morale and quality of appraisals. An action plan had been developed, to address some of the concerns. Actions included, access to leadership training to improve staff engagement, appraisal training to improve the quality of appraisals and a newly implemented governance structure to improve communication and engagement.

The service engaged well within their local cancer alliance and fed back information about the alliance through management meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Adaptive radiotherapy was being used for bladder and gynaecological cancers. Adaptive radiotherapy temporally changes the treatment plan to adapt to the treatment site on the day of treatment. For example, bladders are different sizes depending on how full they are; adaptive bladder radiotherapy allows the treatment plan to be altered based on the bladder’s state. This allows for more accuracy. The service had presented their findings on this method at the European Society for Radiotherapy and Oncology (ESTRO) conference.

Advanced techniques to treat cancers including partial laryngeal image guided radiation therapy (IMRT) were used. While traditional radiotherapy treatment involves treating the entire voice box, the method involved treating the tumour directly. IMRT offers the potential to spare surrounding tissues.

Leaders had developed a patient care improvement group which met bi-monthly and considered clinical reviews, for example, reviews of patients with prostate cancer and how the group could improve care for patients on this pathway.

The service leaders had improved access to treatment and workflow challenges by increasing the services opening hours since our last inspection to allow for more patients to be treated.
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

• The QEII Hospital Urgent Care Centre
• Lister Hospital Emergency Department

There is an urgent care centre (UCC) based at the Queen Elizabeth II (QEII) Hospital. The service is led by emergency nurse practitioners (ENPs) and operates 24 hours a day, 365 days a year. It provides ‘urgent unscheduled care’ needs for adults, young people and children of all ages.

The service provides face to face clinical assessment and treatment for NHS patients who have urgent minor injury / illness that are non-life-threatening and are assessed as not needing the facilities and resources of an emergency department, or intensive or specialist care. The service is provided without the need for an appointment and services also include diagnostic testing and radiology (onsite between the hours of 8am to 11pm and at Lister Hospital outside of these hours). Minor injuries are treated by specialist nursing staff employed by East and North Hertfordshire NHS trust and minor illnesses are treated by GPs from another organisation. We did not inspect the GP services on this occasion.

A summary of the service provided at the QEII Hospital includes:

• Initial triage
• Reception, booking and waiting
• Initial clinical assessment/ triage
• Assessment and treatment
• Discharge
• Education and health promotion information
• Onward referral if appropriate

(Source: Routine Provider Information Request (RPIR) – Context acute)

A consultant-led emergency department is provided at Lister Hospital in Stevenage. Most of the clinical staff rotate from the emergency department and most of their training and development takes place there.
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, February 2018 to January 2019

(Source: Hospital Episode Statistics)

41,020 patients attended the UCC during the year ending June 2019. Children aged 17 years or under represented 29% of patients. Staff employed by East and North Hertfordshire NHS trust treated 42% of patients and GPs treated 58%.

Urgent and emergency care attendances resulting in an admission

The percentage of urgent and emergency attendances at this trust that resulted in an admission increased slightly in 2018/19 compared to 2017/18. In both years, the proportions were higher
than the England averages.

(Source: NHS England)

**Urgent and emergency care attendances by disposal method, from February 2018 to January 2019 (trust wide)**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>25,025</td>
</tr>
<tr>
<td>Discharged*</td>
<td>109,275</td>
</tr>
<tr>
<td>Referred^</td>
<td>1,203</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>100</td>
</tr>
<tr>
<td>Died in department</td>
<td>101</td>
</tr>
<tr>
<td>Left department#</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>683</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged 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)

There were no unplanned admission facilities at the QEII hospital. Any patient who was likely to need urgent admission was transferred to the Lister Hospital in Stevenage.

The last inspection of the UCC was in March 2018 and it was rated inadequate for safe and well-led, requires improvement for effective, and good for caring and responsive. The service was rated as inadequate overall. We carried out this inspection of urgent and emergency care services provided at the QEII hospital from 23 July to 25 July 2019. We spoke with three patients, their families and 14 members of staff, including receptionists, all levels of clinical staff and managers. We observed care and treatment and reviewed 17 patient records. We also reviewed the trust’s performance data and looked at trust policies.

**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 including the highest level of life support training to all staff and made sure everyone completed it.

**Mandatory training completion rates**
Nursing staff received and kept up-to-date with their mandatory training. The trust set a target of 90% for completion of mandatory training.

**The QEII Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the urgent care centre at the QEII Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>10</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>10</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>10</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>8</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Documents seen by us during the inspection showed that further training had taken place since March 2019 and that all staff had now completed all eight modules.

The mandatory training was comprehensive and met the needs of patients and staff. There had been increased attention paid to resuscitation training in the last year. Records supplied by the trust showed that all emergency nurse practitioners (ENPs) had completed training in immediate life support (ILS) and paediatric immediate life support (PILS). This ensured that there was always someone present who was able to commence the resuscitation of adults and children. The majority (95%) of other nursing staff also had current ILS and PILS qualifications.

Clinical staff told us they completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia. The recognition and assessment of people with mental health needs, learning disabilities, autism or dementia was not included in mandatory training. However, staff that we spoke with told us that they had received training in these issues and were aware of how to provide a first response.

Managers monitored mandatory training and alerted staff when they needed to update their training. The unit manager showed us the computer-based documents used to monitor the training status of all staff.

**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.

During our last inspection we found that staff at the UCC did not have access to the local child protection register and we told the trust they must correct this. During this inspection we found that the centre’s computer system linked automatically to the Hertfordshire electronic child protection information system (CP-IS). This immediately alerted staff if a child attended who had already been identified as being at risk of abuse. There were plans to link the system to the national CP-IS.

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff we spoke with were able to explain the process of safeguarding a patient and provided us with specific examples of when they would do this. The clinical computer system had readily available prompts to help them assess vulnerable adults and children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the records of eight children and seven adults and found they all contained relevant levels of safeguarding assessments. Staff were aware of how to contact the safeguarding leads if necessary.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. An external health visitor 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.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw that UCC staff completed referral forms for vulnerable families which were sent to the local safeguarding team.

Safeguarding training completion rates

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

The QEII Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the urgent care centre at the QEII Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
At the QEII Hospital the 90% target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

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

The Intercollegiate Document on safeguarding children and young people (2014) stated that clinical staff who are involved in assessing children should have Level 3 safeguarding training. Records shown to us by the trust demonstrated that 95% of nursing staff had attended this training and the remainder of staff were booked to receive this training in August 2019.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. We observed all areas of the UCC to be visibly clean during our inspection. Staff received training about infection prevention and control (IPC) and hand hygiene training during their initial induction and annual mandatory training.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff demonstrated good hand hygiene during the inspection and either used hand gel or washed their hands at the appropriate time. All staff were ‘arms bare below the elbows’ and they wore personal protective equipment as required. Trust policies were adhered to and staff wore minimal jewellery in line with the trust’s infection prevention and control policy. Hand hygiene gels were available for use at the entrance and throughout the MIU. These measures were in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Handwashing facilities were appropriate and accessible. The most recent hand hygiene audit showed that all staff complied with trust policy.

Staff cleaned equipment, cleaning records were up to date and demonstrated that all areas were cleaned regularly. Areas had been appropriately cleaned with approved cleaning agents. We observed staff cleaning equipment before it was used for subsequent patients. Control of substances hazardous to health (COSHH) risk assessments in place to support staff’s exposure to hazardous substances. Monthly cleaning audits were carried out and consistently achieved compliance of 98% or above. We saw cleaning records of the toys in the waiting room which showed they were cleaned nightly with the correct cleaning agents.

Staff disposed of clinical waste safely. Clinical waste was appropriately stored and disposed of. There was correct segregation of clinical and non-clinical waste into different coloured bags. Sharps bins were labelled, and the bins were not overfilled. This was in line with the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations’.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment did not follow national guidance. 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. However, there was no audio and visually separated waiting area for children in line with national guidance. We raised this concern at our previous inspection and some actions had been taken. A waiting area for children had been created with a variety of toys and books for different ages. However, it was not separate from the adult waiting area. This did not meet national guidance for emergency care settings for children and young people published by the Royal College of Paediatric and Child Health (‘Facing the future; standards for children in emergency care settings’ RCPCH, 2018). The guidance states ‘Children should be provided with waiting and treatment areas that are separate from adult waiting areas’. Department of health guidance (HBN 15-01) also states that for children ‘The [separate] waiting area should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting’. This did not feature on the UCC risk register which meant that we were not assured that all practicable steps had been taken to mitigate the associated risks.

The clinical areas were light and spacious which helped people with mobility aids and wheelchairs to move around safely. Patients were seen and treated in large consulting rooms with enough space for a whole family if necessary.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. We saw maintenance records showing a programme of maintenance and servicing was planned for and had taken place. We checked a range of specialist equipment, including adult and children’s resuscitation equipment. This was contained in a large “tamper-evident” trolley and was clean, clearly organised and well maintained. It had been checked in line with trust policy.

Assessing and responding to patient risk

Staff completed initial risk assessments for each patient. They identified risks but did not always update assessments. Staff identified patients at risk of deterioration but did not always take appropriate actions in line with policy.

Staff used a nationally recognised tool to identify deteriorating patients; however, staff did not always escalate them appropriately. Staff had been trained in the use of the national early warning system (NEWS2) and the paediatric early warning system (PEWS). This was a quick and systematic way of identifying patients whose clinical condition was at risk of deteriorating for escalation. It requires staff to undertake observations at specific intervals to identify changes in a patient’s condition. Patients records we viewed showed that these were used sometimes and escalated appropriately when necessary. However, audits undertaken by the service from May to July 2019 demonstrated that observations were not always taken as per policy scoring an average of 63%. The audits demonstrated that when an elevated NEWS/PEWS was identified this was not always escalated and actioned appropriately scoring an average of 34%. This meant that we were not assured that staff always took appropriate actions in line with trust policy. We saw that this had been discussed at clinical governance meetings; however, there were no clear actions identified to improve performance.

The management of patients with suspected sepsis (a serious blood infection) was not clear. This meant that there was a risk that treatment could be delayed due to a lack of clarity about the
process. The official policy was that any patients suspected of having sepsis (NEWS score of 5 or more) should be transferred immediately by blue light ambulance to the emergency department at the Lister Hospital. However, there were sometimes delays in ambulance attendance to the UCC which could impact on the ability to start sepsis treatment within the hour in line with national guidance. In practice, the nurses would undertake further assessments that were designed for GPs by the UK Sepsis Trust. Nursing staff would then ask the GP to start treatment. However, we could find no clinical guidance for the GPs to follow in this situation. It was not clear whether the intravenous antibiotics required were readily available in the QEII hospital. Two nurses explained that these arrangements had been developed because they sometimes had to wait for 40 minutes for an ambulance to arrive. Staff were aware that treatment for sepsis needed to commence within one hour and had developed this way of working to try and achieve that. The UCC leadership team were aware of these issues relating to ambulance delays and they had been entered onto the risk register. However, there was a risk of inconsistent treatment because of a lack of agreed written guidance for suspected sepsis when ambulances were delayed which had not been identified.

The nurses that we spoke with during inspection were aware of the process for managing sepsis. They were able to describe cases of suspected sepsis that had recently been diagnosed and the emergency transfers to an emergency department that had resulted. Data from the trust showed that all ENPs had been trained in the recognition and treatment of sepsis. However, the risk register showed that, as of 22 July 2019, not all triage nurses had received this training. The matron explained that this was due to new triage nurses being appointed. After our inspection, we received updated information which demonstrated that 98% of ENPs and band 5 registered nursing staff had completed the required sepsis management training.

There had been several improvements in the initial clinical assessment of patients during the last year. At our last inspection we found significant weaknesses in this process and told the trust that it must improve.

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools. One of our previous concerns had been the length of time it took before patients were clinically assessed. We had observed delays of up to 40 minutes and there was a risk that urgent conditions would not be recognised quickly enough resulting in delays in treatment. During this inspection, a specially trained nurse assessed all patients as soon as they arrived. The nurse was based at the reception desk which meant that a brief assessment took place before the patient was registered. We did not see any queues to see the nurse and staff told us that they rarely occurred. The assessment nurse could see patients as they came through the entrance doors and would bring forward anybody who looked particularly ill or distressed. The nurse could also observe patients in the waiting room and was able to quickly assist anyone whose condition unexpectedly deteriorated.

If more detailed assessment was required, such as recording of blood pressure, temperature or heart rate, patients would see a second nurse inside the UCC. We observed the detailed assessment of three patients (with their consent) and found it to be thorough and effective. The nurse had completed special training in triage and had been assessed as competent before undertaking the role. The process was assisted by the clinical computer system which was based on the Manchester Triage system. This used five triage categories to prioritise patients’ treatment. Category one patients needed to be treated immediately and category four patients were safe to wait for two hours. Category five meant that the patient’s condition was non-urgent. At our last inspection an old version of the Manchester Triage system was being used. Nurses were not familiar with it and this had led to confusion in deciding triage categories. Since then, the software
had been updated so that it was the same as the version used at the Lister hospital emergency department. We observed patients being prioritised according to their level of risk.

The figures below demonstrate the time to the second, more detailed clinical assessment. In practice, almost all patients are assessed as soon as they arrive.

**Median time from arrival to initial assessment (all patients)**

**The QEII Hospital**

The median time from arrival to initial assessment at the QEII Hospital ranged from five to 11 minutes over the 12-month period from April 2018 to March 2019. In March 2019, the median time from arrival to assessment at the QEII Hospital was seven minutes.

**Time to initial assessment from April 2018 to March 2019 at The QEII Hospital**

![Graph showing time to initial assessment from April 2018 to March 2019 at The QEII Hospital]

(Sources: NHS Digital - A&E quality indicators, Routine Provider Information Request (RPIR) – AC6 – Time to initial assessment)

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

**The QEII Hospital**

There is no data available for ambulance turnaround times at the QEII Hospital as less than one patient a week was brought by ambulance. (42 patients in the year ending June 2019). Staff told us that they were assessed by a nurse as soon as they arrived.

Staff knew about and dealt with some specific risk issues. There was no cardiac arrest team in the hospital, but all staff had current immediate life support qualifications (for adults and children). They knew to call an emergency ambulance if a patient’s heart or breathing stopped and could start resuscitation whilst waiting for the ambulance to arrive.

There was no paediatric team at the QEII hospital but ENPs were trained to assess and treat children with minor injuries. A programme of rotation to the children’s emergency department had now been introduced to improve the assessment skills of triage nurses.
Nurses told us that when children presented to the UCC with an illness, they would be seen by one of the GPs who worked there. If they arrived after midnight (when the GPs had left) they would be assessed by an ENP and re-directed to the out-of-hours GP service or the emergency department at the Lister hospital. Staff could contact children’s doctors and nurses at the emergency department if they needed specialist advice.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. At our last inspection there was no system for assessing whether patients arriving with mental health problems were high, medium or low risk. Since then the leadership team had worked with the neighbouring mental health trust to develop a risk assessment that was suitable for patients who attended the UCC. It was comprehensive, but easy to use and gave clear guidance to staff depending the level of patient risk. The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health.

The new matron had realised that the mental health risk assessment was not always suitable for children with mental health problems. Further work had taken place and an age-specific risk assessment was approved by the divisional governance group during our inspection.

**Nurse staffing**

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.** Managers had reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing staff of all grades to keep patients safe. 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 registered 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.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance. A staffing review had taken place April 2019 and a need to increase the number of registered nurses had been identified. This was to ensure one additional registered nurse was on duty each day between 10am and 10pm when the UCC was at its busiest. Recruitment had taken place in May and June and we found that, by July 2019 85% of the additional shifts had been filled. The matron could adjust staffing levels daily according to the needs of patients. On days when the planned staffing did not meet the actual staffing levels the UCC matron would often work clinically to ensure that there were no delays in patients’ treatment.

**The QEII Hospital**

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at the QEII Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
<th></th>
</tr>
</thead>
</table>

20191218 RWH Post-inspection Evidence appendix FINAL
<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>13</td>
<td>-2%</td>
<td>5%</td>
<td>3.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>8</td>
<td>19%</td>
<td>4%</td>
<td>2.2%</td>
<td>1,917</td>
<td>0</td>
<td>321</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The service had vacancy rates above the trust target. The service had turnover and sickness rates below the trust target.

Nurse staffing rates within this core service at the QEII Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness, bank use and agency use.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank and agency staff had a full induction so they understood the service. No agency nurses had worked in the UCC in 2019. We spoke with one bank nurse who worked in the centre on a regular basis and who confirmed that there had been an induction process when they started.

**Records**

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

Patient notes were comprehensive and all staff could access them easily. 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. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.

Records were stored securely. The paper sheet was placed in a box at the back of reception so that clinical staff knew which patients were waiting. The records were supervised at all times. The GPs and nursing staff used different computer systems which meant that observations recorded by nurses could not be seen on GP screens. Therefore, nursing observations were recorded on a small form which was securely attached to main patient record. We told that the observations were then entered on to the computer by the GPs.

The management of records had improved since our last inspection. Although two computer systems were used at the UCC, staff had developed processes to keep track of paper and computer records to avoid any confusion.

We looked at 17 sets of patient records and found that information regarding the patient’s care and treatment was clear and well documented. There was appropriate information to understand the diagnosis and treatment delivered. Discharge summaries were detailed and included the aftercare advice that had been given to the patient. They were sent to GPs on a daily basis.
When patients transferred to a new team, there were no delays in staff accessing their records. Once a course of treatment had been completed the paper records were scanned into the computer system and the paper records were securely destroyed. The records could then be viewed on screen if a patient returned to the department.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Medicines were stored in line with trust medicines’ management policy and fridge and room temperatures were regularly checked and temperatures recorded. We found that all temperatures were within an acceptable range.

Some ENP’s had qualified as nurse prescribers. Non-prescribing clinical staff such as nursing staff administered selected medicines under guidance, known as patient group directions (PGDs). We looked at PGD’s used in the UCC which were now up-to-date and appropriately completed. This had improved since our last inspection. The UCC matron regularly reviewed practice to ensure staff competency. However, there was no PGD for anaesthetic skin gel which is often used for children whose wounds need to be stitched.

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**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

All staff we spoke with knew what incidents to report and how to report them. Incidents and accidents were reported using a trust wide electronic system and were graded in severity from low or no harm to moderate or severe. The trust had an incident reporting policy, which described the process for grading and reporting incidents. Staff were able to access this on the trust’s internal website. The matron was familiar with the incidents that had been reported from the unit and was able to discuss the themes that arose from them.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that learning from incidents and alerts was shared between all units in the urgent and emergency division via a three-monthly newsletter. The matron and other members of the team attended divisional meetings where serious incidents and associated learning were discussed. Themes from incidents were discussed at UCC monthly team meetings.

**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 June 2018 to May 2019, the trust reported no incidents that were classified as a never event in urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

There were no serious incidents in the UCC for year ending June 2019.

Is the service effective?

Evidence-based care and treatment

The service had improved the provision of care and treatment based on national guidance and evidence-based practice. Managers were now checking to make sure staff followed guidance.

Staff now followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The availability of evidence-based guidance had improved since our last inspection. Then we had found that it had been over 10 years since the clinical guidance available to staff had been reviewed and it was not clear whether practice in the UCC was following national guidance. Now we found that staff generally followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The UCC met all of the 19 principles set out by the Royal College of Emergency Medicine (RCEM) document ‘Unscheduled care facilities’ 2009. This was an improvement on our previous inspection.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were aware of the requirements of the Mental Health Act but said that very few patients attended the centre with mental health problems. No patients with mental health problems attended during our inspection.

There was no evidence that the service was working towards meeting the standards in the intercollegiate document published by the Royal College of Paediatric and Child Health (‘Facing the future; standards for children in emergency care settings’ RCPCH, 2018). The guidance has a self-assessment tool which all urgent and emergency care services (including urgent care centres) are encouraged to complete to ensure they meet the minimum standards in the document. The minimum standards set for emergency settings for children are:

- Designated, appropriately designed waiting room for children and young people with space for parents/carers and buggies
- Designated areas suitable for breastfeeding and nappy changing.
- Appropriate safe area for children with mental health needs (e.g. a ligature free environment that may involve removing furniture and equipment).
- A cubicle with a door for consultations where privacy and confidentiality is paramount.
- Facilities for the full resuscitation and also monitoring of high dependency children, as well as those treating more minor illnesses/injuries.
- A route to the imaging department which avoids other areas of the emergency care setting if possible.
The guidance acknowledges that different models of urgent care provision may not be able to meet these standards for a number of reasons including space and environment. However, it is anticipated that use of the assessment tool will help services identify areas for improvement and potential patient safety risks.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. For example, a specific children’s pain assessment tool was used when children were too young to describe their pain. There had been improvements in assessing and relieving pain. During our last inspection we had found that pain assessments were rarely recorded, and pain relief was sometimes slow to be given. We told the trust this must improve. During this inspection we reviewed the records of 15 patients who were likely to have pain. All but one had a pain score recorded. Patients with significant pain had been given pain relief during their initial assessment. Emergency nurse practitioners (ENPs) re-assessed pain levels when they treated patients.

The service conducted monthly audits of whether or not a pain score was recorded at initial assessment. From May to July 2019, the service scored an average of 84% which was above the trust lower level of compliance of 75%.

Patients received pain relief and staff prescribed, administered and recorded all pain relief accurately. However, we noted that nurses could not administer any pain relief stronger than paracetamol or ibuprofen. This may not be sufficient for patients with broken bones.

**Patient outcomes**

The service now monitored the effectiveness of care and treatment. They were developing ways to use the findings to make improvements and achieved good outcomes for patients.

Managers had developed a local audit programme and had started to use the information from the audits to improve care and treatment. The UCC still did not participate in national clinical audits relevant to the service, but managers carried out a detailed local audit programme. This was an improvement from our previous inspection. The audit programme included pain management, risk assessments, early warning scores, ECG recordings, medicine administration and quality of clinical records. We saw that the results of audits were discussed at quality meetings to identify areas for improvement and the service was meeting the compliance in most areas. However, it was not always clear how information was used to drive improvements. For example, minutes from a quality meeting in February 2019 confirmed that elevated early warning scores were not being escalated and actioned appropriately. At the time of the February meeting the score was recorded as ‘in the 60s’. However, more recent data demonstrated that from May to July 2019 this score was now an average of 34. This meant we were not assured that the audit data was being used to help drive improvements.

Managers shared and made sure staff understood information from the audits through team meetings and departmental newsletters.

**Unplanned re-attendance rate within seven days**
The service had a lower than expected risk of re-attendance than the England average. Data from the trust indicated that, for the year ending June 2019, the unplanned re-attendance rate was nil compared to the England average of 7.9%.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held meetings with them to provide support and development.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, some nursing staff were being supported to acquire competencies required to become emergency nurse practitioners.

Managers made sure staff received any specialist training for their role. There were no registered children’s nurses working in the department although 29% of patients were ages 17 years or less. Although ENPs were qualified to assess and treat children, other registered nurses did not have these specialist skills. We had raised this as a concern at our previous inspection. Senior leaders recognised that triage nurses needed further training and had arranged for them to rotate to the children’s emergency department to gain tuition and experience. After our recent inspection, the trust told us that all registered adult nurses had received this training and had competencies signed off by an appropriate practitioner at the Lister Hospital children’s emergency department. In addition all staff were now compliant with paediatric immediate life support training. However, we did not see evidence that competency frameworks were linked to higher education institutions or national standards.

Managers gave all new staff a full induction tailored to their role before they started work. This included orientation to the UCC and trust policies. The service had introduced a new induction pack since our last inspection in 2018 which the trust told us was received positively by new starters.

**The QEII Hospital**

From April 2018 to March 2019, 80.0% of staff within urgent and emergency care at the QEII Hospital received an appraisal compared to a trust target of 90%. Care should be taken when interpreting appraisal rates due to a low number of staff in some staff groups.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>2</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>2</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Records shown to us during the inspection showed that, by July 2019, all nursing staff had received an appraisal.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff worked across health care disciplines and with other agencies when required to care for patients. 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.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There were effective links with other services such as health visitors, mental health teams, community nurses, and social services. There was particularly close co-operation with the X-ray department. This provided a service to local GPs. If radiographers found that GP’s patients had a fracture they would refer them to the UCC for immediate treatment.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The UCC was open seven days a week for 24 hours a day.

Imaging facilities were available at the UCC every day from 8am to 11pm. However, patients could be referred to the acute hospital site if specific test were required.

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. The service was actively developing plans and working with the pharmacy team to increase on-site provision of pharmacy support for evenings and weekends.

A stock of frequently required medication was kept in the unit which could be dispensed to patients when the pharmacies were closed.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on the unit.
We observed staff giving patients advice about how to prevent accidents and how to care for injuries when they left the hospital. There was also 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 supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We observed that consent was obtained for any procedures or examinations undertaken by the staff. ENPs that we spoke with had sound knowledge about consent and mental capacity. They had received training in the application of the mental capacity act and deprivation of liberty safeguards but could not remember the last time they had had to use it in the UCC. They were able gain advice from local psychiatric crisis teams if this was necessary.

The ENPs 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 enough 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. Further written guidance on consent, and assessing mental capacity was available via the trust’s intranet.

**Training rates**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training is delivered as part of the adult safeguarding module.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at the QEII Hospital for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>10</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>10</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was met for both of the MCA/DOLS training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

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.

Confidentiality was maintained at the reception desk by means of signs asking people to stand back from the desk when someone else was giving confidential information. The UCC had examination and treatment rooms with doors to ensure privacy when patients were being seen and examined. We saw that staff knocked and waited to be called in before entering.

Staff introducing themselves and explaining what was about to happen before examining patients. 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.

Practitioners took time to distract and comfort children during examinations and wound cleaning. There were boxes of toys that could be taken to children wherever they were in the unit. Parents told us they were involved in the assessment and treatment of their children and clear explanations were given. We spoke with three patients and their families and all spoke positively about the care they had received. They told us that all staff had treated them kindly and with compassion.

Friends and Family test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

For the year ending June 2019 97% of patients said that they would recommend the UCC to friends and family. We noted that feedback rates had improved in 2019. During 2018 only 0.8% patients responded to the survey. From January to June 2019 this had improved to 4.5%. The service had plans to further improve the response rate.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff that we spoke to were aware of the impact that a person’s treatment, care, or condition could affect them both emotionally and socially. They took time to reassure patients emotionally, as well as treating their physical injuries. Patients told us that staff took time to reassure them and listen to their concerns. We saw that patients who needed extra time for their treatment due to communication needs were supported by staff. There was a calm but cheerful atmosphere in the UCC and patients told us that they found this reassuring.

Staff told us they directed patients to relevant external organisations for further support when required.
Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The patients that we spoke with all told us they were satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place. They had been given options of returning to the UCC or being referred to their local GP practice.

We saw staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do. They also checked that people had understood what they’d been told and what needed to happen next.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Patients that we spoke with said that they appreciated having an urgent care centre (UCC) in Welwyn Garden City. It meant that they did not have to travel to the emergency department at Stevenage. Older people who did not drive and were reliant on public transport were particularly appreciative.

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 enough 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.

The UCC was currently working with the local clinical commissioning group to see if it was possible to become an urgent treatment centre. This would enable patients with minor illnesses to be given appointments with the GPs in the centre.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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 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.
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.

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

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Waiting times for treatment were displayed on a whiteboard at reception. This was updated every hour so that patients were aware of how much longer they had to wait. There were often longer delays seeing a GP but the information board did not give these details. This occasionally led to verbal complaints from some patients because they saw patients with minor injuries being called in for treatment before them.

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 should be no more than one hour.

Data supplied by the trust showed that the average (median) time to treatment for the year ending June 2019 was 62 minutes. This was similar to the England average of 61 minutes.

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

Managers and staff worked to make sure patients did not stay longer than they needed to.

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

Data supplied by the trust showed that, in the year ending June 2019, 99.6% of patients were treated and discharged or transferred within four hours. This was better than the England average of 88%.

Percentage of patients waiting more than four hours from the decision to admit until being admitted

No patients were admitted to the QEII hospital. Any patient likely to need admission was transferred to the emergency department at the Lister Hospital.

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

The number of patients leaving the service before being seen for treatments was low.

In the year ending June 2019 2.3% of patients left the UCC before being seen for treatment. This was better than the England average of 2.8%. To ensure that treatment was not required nurses
would phone patients the following day to discuss any concerns.

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

For the year ending June 2019 the average (median) total time per patient in the UCC was 84 minutes. This was better than the England average of 150 minutes.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

**Summary of complaints**

For the year ending June 2019 the UCC received 11 complaints. All of them had been acknowledged in writing within three days although only 65 % had been investigated and completed within the trust target of 35 working days. Minutes of a UCC performance and quality meeting (January 2019) showed that the four incomplete investigations were complex and sometimes involved other services. For example, one patient complained that staff had refused them treatment even though they had an appointment. Since the UCC did not operate an appointment system it was likely that the patient had confused them with another service which needed to be established. The process of gaining further information from the patient to clarify the situation had proved lengthy and difficult.

**Number of compliments made to the trust**

Staff told us that the UCC received many more compliments than complaints and we saw some of them displayed on the staff noticeboard.

The trust stated that compliments are received via the CEO office, these are responded to and sent to the relevant areas by the CEO. They are then shared with the complaints team for recording.

The trust also stated that they received multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust is currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.
Is the service well-led?

Leadership

Leaders were new to the service however, they had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been significant improvements in leadership. At our last inspection we had found that there was confusion at all levels regarding the leadership of, and accountability for, the urgent care centre (UCC). We told the trust this must improve.

The UCC was part of the emergency and acute medicine directorate which, in turn, was part of the medicine division. Since April 2019 new people had been appointed to the posts of UCC matron and general manager. A new post of clinical lead had also been created and a consultant from the Lister emergency department had been appointed to it. Staff at all levels told us the new team had greatly improved the organisation of the UCC. They told us that there was a cohesive working relationship between the three leaders and remarked upon the speed of progress the centre had made since their appointment.

The leadership team were highly visible in the clinical environment supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose. They demonstrated the skills, knowledge and experience needed for their roles. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns.

Staff told us that they were encouraged to develop their skills and take on more senior roles. One described a leadership programme that they were involved in. This was known as LEND (Listen, Empower, Nurture, Develop) and consisted of group sessions and one-to-one coaching. Several staff spoke very highly of the programme.

Vision and strategy

The service had a vision for what it wanted to achieve and were developing a strategy in line with the trust’s overall strategy. The trust’s strategy was focused on sustainability of services and was aligned to local plans within the wider health economy.

At the time of our inspection, there was not a formalised separate strategy for the UCC. The recently appointed senior leaders were in the process of drafting the strategy and described the priorities. The matron described a vision for the UCC which included progression to the status of urgent treatment centre and included a separate children’s treatment area. This was aligned to plans described by the local clinical commissioning group (CCG). Meetings were being held with the CCG to monitor the progress of the plans.

We asked the trust for a copy of the strategy that included the UCC. They sent us the trust’s clinical strategy for 2019-2024 but it did not contain any information about the UCC.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided
opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that the culture within the department had improved since our last inspection. They now felt that they were “listened to” and that any concerns or suggestions they might have would be taken seriously.

Staff were consulted about proposed changes within the service. For example, a pilot study was carried out before the implementation of a new mental health assessment tool. Following feedback from the staff changes were made so that it was easier to use and more effective.

There was a strong emphasis on the safety and well-being of staff. There was a designated security guard in the UCC. In order to improve safety, the matron had identified a “Safe Room” for staff and any patients if they felt threatened. Its main purpose was as a treatment room for applying plaster casts, but it was the only room in the UCC that could be locked from the inside. A telephone had been installed so that staff could call for help from inside the room.

**Governance**

**Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff were not always clear about their roles and accountabilities. However, the service now had regular opportunities to meet, discuss and learn from the performance of the service.**

Governance of the UCC had improved. However, we were still not assured that all levels of management and governance functioned and interacted effectively yet.

At our last inspection there was no systematic approach to clinical governance or to continually improve the quality of services offered to patients. We told the trust this must improve.

At this inspection we found that some improvements had been made. For example, the matron and general manager had now started to regularly monitor quality indicators through internal audits, incidents, complaints and compliments. Trends in all of these were discussed at local governance and performance meetings to identify areas for learning and improvement. Whilst this was an improvement since our last inspection, it was too early to measure if the service was effectively monitoring and assessing the quality of care to drive necessary improvements (please see effective section of report for further information).

During the inspection, we found that staff were not always clear about their roles. The systems of accountability to support the delivery of sustainable services was not yet embedded. For example, there was a lack of clarity around the process for treating patients with suspected sepsis and no formal arrangements had been made with the external GP provider.

There were monthly performance and governance meetings which were held jointly with a representative from the GPs who also worked in the UCC. Every third meeting involved senior leaders from the medicine division so that any wide-ranging concerns could be addressed. This ensured that the division had oversight of the UCC.

All matrons in the trust attended weekly safety huddles (brief meetings where important information was exchanged). The UCC displayed the notes from these meetings on noticeboards in staff areas and discussed them with staff at drop-in sessions.

**Management of risk, issues and performance**
Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and issues and were now identifying actions to reduce their impact. They had some plans to cope with unexpected events; however, staff were still not aware of their responsibilities in the result of a major incident.

At our last inspection we had found that the UCC did not have a risk register, there was no monitoring of performance and staff were unsure about how to respond if there were unexpected events such as prolonged power cuts, loss of water supply or a major incident. At this inspection we found some improvements had been made.

There was an up-to-date risk register that contained details of risks identified by staff and previous inspections. It included the management of sepsis and the ability to assess sick children. The highest risk was the long waits for ambulances when a patient required immediate transfer to the emergency department at the Lister Hospital. Each risk had an action plan with regular reports on progress. Moderate and high risks also featured on the divisional risk register. Many of the risks that we had identified at our last inspection had been reduced. However, some of the risks that we found on this inspection did not feature in the risk register, this included the treatment for patients with sepsis when ambulances were delayed and the lack of dedicated children’s waiting area.

Although the Service Specification for the UCC stated that it would receive appropriate patients from a major incident, the centre was not included in the trust’s major incident plan. Staff that we spoke with were not aware of their role in a major incident and there were no action cards to guide them. This had not improved since our last inspection.

There was a trust-wide business continuity plan to guide staff in responding to serious and unexpected events. It contained general advice but did not give specific details about action to be taken in the UCC. The leadership team had recognised this and were in the process of aggressing and providing the required information. Senior staff had recently been trained as fire marshals so that they could respond quickly and effectively if the fire alarm sounded.

There were monthly performance and governance meetings where results of performance monitoring was discussed. Minutes showed that issues such as triage processes, delays to see GPs, peaks in demand for X-rays and access to IT systems were addressed.

Information management

The service could not always collect reliable data in order to analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated although they were secure. Data or notifications were consistently submitted to external organisations as required.

During our inspection the clinical computer system stopped working for 21 hours. A senior member of staff told us this was the third time it had stopped working in the last two months. There was a well-rehearsed paper-based back up system that worked well. However, it meant that information had to be retrospectively entered when the computer system became functional again. Staff estimated that they would have to manually enter almost 100 patient records following this latest shut down. Much of the information related to the examination of patients and could only be re-entered by clinical staff. This process was time consuming and there was a risk of errors being made.

It was not always easy for staff to find the information that they needed. It was not possible to search the data by diagnosis or by time of day. This made gathering information difficult for clinical
audits and performance management. The system did not gather all the information needed by external organisations. For example, data supplied by the trust stated that there had been no unplanned patient re-attendance in the last year. The national average is 7.9% of patients and we were aware of at least one unplanned re-attendance during the inspection.

The GPs working in the UCC used a different computer system to the nursing staff. Although there was no link between them staff managed record systems effectively to prevent confusion.

The matron was aware of these issues. They had been raised with the trust’s IT department and entered onto the UCC risk register.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The matron took part in the six-weekly “Team time” education sessions for ENPs. This enabled staff to discuss concerns or propose changes. All staff rotated between the UCC and the emergency department at the Lister and so attended regular staff meetings in the emergency department. However, minutes showed that issues relating to the UCC were not discussed at those meetings. The new leadership team had recognised this and had arranged “drop-in sessions” so that staff could discuss proposed changed or share any concerns.

The trust told us there have been engagement sessions held throughout the year at QEII (including UCC) to give staff the opportunity to speak with senior management and executive colleagues. For example the trust run ‘Trust conversation’ events that are run by the chief executive officer and other executive colleagues as well as senior management. Executive drop in sessions had also been held on this site to give staff opportunities to attend. These events are not site specific and staff are encouraged to where possible to attend other engagement events across the other sites within the trust.

The department engaged with patients and the public by means of Friends and Family test (FFT) questionnaires and by inviting feedback via the trust’s website.

The service was working with the local clinical commissioning group to consult with the public about reducing the opening hours of the UCC. Information was exchanged with the public via the hospital website, local newspapers and public meetings. All UCC staff had also been invited to take part in the consultation.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

An innovative method of evidence-based treatment of burns was used at the UCC. If an ENP suspected that a burn needed specialist treatment, they could use a tele-medicine link with the regional burns unit. A photograph of the burns was attached to an electronic referral form and sent via a secure link to the burns unit. It would be viewed immediately by a specialist who could then discuss the treatment of the burns with the ENP. If the patient required treatment at the burns unit an immediate transfer would be arranged.
There had been many improvements in the service since our last inspection. These included leadership capability, risk assessments and identification of deteriorating patients, immediate life support skills, evidence-based care and treatment, staff engagement and competency, culture, safeguarding processes and governance arrangements.

Nurses studying to become advanced nurse practitioners were encouraged to use and take part in research in order to improve treatment.

There was a lead emergency nurse practitioner (ENP) who shared their time between the UCC and the emergency department at the Lister hospital. This was a new role aimed at ensuring that ENPs shared best practice. The lead ENP organised three monthly education meetings at the Lister hospital.
Outpatients

Facts and data about this service

Outpatient services provided by the trust are located at three sites: Lister, Queen Elizabeth II (QEIi) and Hertford County Hospitals. The trust also supports some community-based clinics. In addition, Mount Vernon Cancer Centre (MVCC) supports an outpatient service for the cancer services provided on that site. The service is managed by one management team based at the Lister Hospital, and forms part of the clinical support services (CSS) division. Information technology systems (IT) that support outpatient services across all three sites are provided at the Lister Hospital.

Due to leadership and medical staffing for the service being largely based at the Lister Hospital, there will be some similarities in information across all outpatient reports. The trust provided some information at a divisional level and therefore, not service specific. The report will clearly indicate where this occurs.

The outpatient department at the Queen Elizabeth II Hospital is located over three floors. Blood tests and fracture clinics are located on the ground floor, with specialist clinical departments for ears, nose and throat (ENT), ophthalmology and oral surgery and orthodontics located on the first floor. Also located on the first floor are general outpatient clinic areas A and B, which run specialty based clinics such as gastroenterology, gynaecology, and dermatology. Breast clinics and a separate children’s outpatient department are located on the second floor. Some children were seen in general outpatient clinics dependent on specialty including trauma and orthopaedics.

There are consultant and nurse-led outpatient clinics across a range of specialties, which are provided in the outpatients’ department. Outpatient clinics are held Monday to Friday from 8.30am to 5.30pm. There were no outpatient clinics provided at weekends. The outpatients’ service is part of the clinical support services division. The current structure includes a divisional chair, a divisional director, a head of nursing.

During our announced inspection from 23 to 25 July 2019 we visited clinics and departments including ophthalmology, oral surgery and orthodontics, fracture clinic, phlebotomy, ENT, rheumatology, gastroenterology, gynaecology, dermatology, breast clinic, and the children’s outpatient department.

We spoke with 11 patients or their relatives, observed patient care and treatment and looked at eight patient care records. We spoke with 25 members of staff, including doctors, department managers, nurses, health care assistants, and administrative staff. We also considered the environment and held focus groups attended by trust staff prior to the inspection and reviewed the trust’s outpatient performance data.

The inspection team consisted of an inspector. Outpatients was previously inspected in October 2015 as part of the outpatients and diagnostic imaging core service, and was rated good for safe, caring, responsive and well-led. We did not rate effective. The overall rating was good. This is the first inspection of outpatients as a core service independent of diagnostic imaging.
Total number of first and follow up appointments compared to England

The trust had 611,317 first and follow up outpatient appointments from February 2018 to January 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from February 2018 to January 2019.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lister Hospital</td>
<td>520,587</td>
</tr>
<tr>
<td>Queen Elizabeth II Hospital</td>
<td>161,533</td>
</tr>
<tr>
<td>Hertford County Hospital</td>
<td>76,332</td>
</tr>
<tr>
<td>Mount Vernon Cancer Centre</td>
<td>75,291</td>
</tr>
<tr>
<td>*East and North Hertfordshire NHS Trust</td>
<td>2,933</td>
</tr>
<tr>
<td>This trust</td>
<td>836,694</td>
</tr>
<tr>
<td>England</td>
<td>108,838,071</td>
</tr>
</tbody>
</table>
*Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

The outpatient department at the Queen Elizabeth II Hospital handles approximately 160,000 clinic appointments per year. The trust had 611,317 first and follow up outpatient appointments from February 2018 to January 2019. The Queen Elizabeth II hospital had 161,533 of these appointments.

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from February 2018 to January 2019. The percentage of these appointments by type can be found in the chart below:

Number of appointments at East and North Hertfordshire NHS Trust from February 2018 to January 2019 by site and type of appointment.

![Chart showing type of appointments](chart.png)

Note: Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

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

The QEII Hospital

Nursing staff received and kept up-to-date with their mandatory training. The trust had eight training modules for nursing staff which were mandatory. Data provided by the trust prior to the inspection showed that the 90.0% target was met for all the mandatory training modules for which qualified nursing staff at the QEII Hospital outpatient department were eligible. Across all eight modules, the data provided showed an overall compliance of 100.0% for nursing staff in outpatients.
A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at the QEII Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Conflict Resolution - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Health and Safety - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Information Governance - 1 Year</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Moving and Handling - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control-Clinical (including management of inoculation injuries &amp; hand hygiene) 2 year</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Moving &amp; Handling for People Handlers - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
</tbody>
</table>

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

The trust did not report any medical staff working in outpatients at the QEII Hospital. Medical staff were not directly employed by the outpatients’ department, therefore training requirements were the responsibility of the clinical speciality.

The mandatory training was comprehensive and met the needs of patients and staff. Regular mandatory training updates were completed depending on training requirements. For example, data security awareness required annual updated, while conflict resolution required an update every two years. Staff could access mandatory training in a variety of ways and included online eLearning and face-to-face sessions as appropriate. Staff were allocated dedicated time to complete ‘face to face’ mandatory training. Training was completed and entered onto the trust’s electronic system where competences achieved following training could then be awarded. Staff received additional training such as medicines management and adult basic life support (BLS). Data provided by the trust showed 85.7% of staff were complaint with BLS, and 70% were complaint with medicines management. Staff told us medicines management was recently reintroduced to the mandatory training programme.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. While there were training modules for mental health and dementia which were mandatory every three years, they were also included in the Mental Capacity Act (2005) and adult safeguarding training, along with learning disabilities and autism. The outpatient department had link nurses who attended additional training, for example for learning disabilities and dementia, who fed back and supported staff throughout the department.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was reviewed and completed on an annual basis for all staff. All staff were expected to complete mandatory training modules, and compliance was monitored by managers. All staff and their managers received reminders of when training was due to expire,
and staff that we spoke to told us that mandatory training was discussed at their appraisals.

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.

Safeguarding training completion rates

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

The QEII Hospital

Nursing staff received training specific for their role on how to recognise and report abuse. The trust had four safeguarding training modules for nursing staff which were mandatory. Data provided by the trust prior to the inspection showed that the 90% target was met for all mandatory training modules for which qualified nursing staff at the QEII Hospital outpatient department were eligible. Across safeguarding level 2 for adults and children, the data provided showed an overall compliance of 100.0% for nursing staff in outpatients.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the outpatient department at the QEII Hospital is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100.0%</td>
<td>90%</td>
</tr>
</tbody>
</table>

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

While there were no staff across general outpatients who were safeguarding children level 3 trained, there were two registered childrens nurses in the children’s outpatient’s department whom staff could contact for any concerns identified with children. During our inspection, we were told that the outpatient sister, and three band 6 nurses had enrolled on safeguarding children level 3 training due to take place in August 2019, to further improve safeguarding support for the general outpatient department.

Included alongside level two and three safeguarding training, there was guidance on Child Sexual Exploitation (CSE), FGM and PREVENT.

Child Sex Exploitation is a form of child abuse and reportable to children’s social services in line with safeguarding procedures. A toolkit was in place for dealing with patients who were suspected of being subject to CSE which all staff had access to via the intranet. Staff were aware of the potential indicators of abuse, the toolkit to use and how to complete an interagency referral.

FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Senior nursing
staff were aware that they had a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who had given birth to a female infant. This awareness may come from physical examination or from a verbal disclosure. Senior nursing staff knew their responsibility to report this to the police within 24 hours ideally but certainly within 28 days after being made aware of the FGM.

Included alongside safeguarding adults training, there was PREVENT awareness. PREVENT is one arm of the government’s anti-terrorism strategy. PREVENT awareness training explains how to safeguard vulnerable people from being radicalised into supporting terrorism or becoming terrorists themselves. Training figures for outpatients showed that 100.0% of staff had completed the training. There was a PREVENT policy available on the intranet.

The trust did not report any medical staff working in outpatients at the QEII Hospital. Medical staff were not directly employed by the outpatients’ department, therefore training requirements were the responsibility of the clinical speciality.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Nursing and administrative staff regularly checked waiting areas and monitored the well-being of patients prior to their appointment. When asked, staff were aware and could give examples of protected characteristics and potentially vulnerable patients.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nursing staff described how they identified patients at risk of harm and how they would make a safeguarding referral. 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. Most staff knew how to find out who the safeguarding leads were within the trust. Patients who were known to be subject to safeguarding concerns were easily identified on the trust’s electronic patient record (EPR) system. Using an electronic flag, patients were identified with a unique icon next to their name to highlight confidential safeguarding information. The flags highlighted a range of concerns including learning disability, domestic violence, social care involvement, non-English speaker, and looked after children. Safeguarding flags were recorded and updated manually on each patient’s record by the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Nursing staff, healthcare assistants and ancillary staff could explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients. Staff explained the process for making a safeguarding referral and would immediate raise their concerns with the consultant and medical team. Staff described examples of when they would raise a safeguarding concern. Staff were supported safeguarding policies and procedures which were available to staff on the intranet, including out of hours’ contact details for staff. Relevant information and contact details of the trust’s safeguarding team and for the local safeguarding authority teams were seen on staff noticeboards and in public areas.

Staff followed safe procedures for children visiting the department. While children were seen within general outpatient clinics such as fracture clinic, patients under 18 were usually seen in paediatric clinics where all nursing staff were trained to safeguarding children level three and acted as chaperones during consultations. All staff across the outpatient department were aware of the requirement to ensure the safety of children visiting the department. Systems were in place to ensure access to paediatric clinics was limited to specific staff, with key card access on all external doors to clinical areas.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection, and kept the premises visibly clean. However, equipment used by patients was not always clean. There were waiting room chairs across the department which were visibly soiled.

Clinical areas were clean and generally had suitable furnishings which were clean and well-maintained, however waiting room chairs used by patients across the department were visibly soiled. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained, as all areas across the outpatient department were seen to be visibly clean and tidy, with the exception of some equipment used by patients in waiting areas. An external company provided domestic cleaning, and we saw that this was completed at regular intervals. During our inspection we found the general cleaning of the environment in all outpatient areas was consistently of a high standard. Staff told us that they were happy with the level of service they received. Floors, seating, couches, and children’s toys provided in waiting areas were all wipe clean in line with the trust infection prevention and control policy. All couches in the consulting rooms and most observed seating in the waiting areas were in good condition without rips and tears. However, during our inspection we saw there were several chairs with fabric covers which were visibly soiled in waiting areas throughout the outpatient department, specifically Outpatients A and breast clinics. We raised our concerns with the outpatient sister, who told us that the trust has been aware of the issues for some time. Following our inspection, we saw evidence that replacement furniture was due to be replaced and a review conducted to remove the damaged chairs.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits were completed across the outpatient department at varying frequencies. Areas in a high risk category were audited monthly, for example public and staff toilets, while significant risk areas were audited on a quarterly basis and included all clinical and non-clinical areas accessible to patients, such as fracture clinic, breast clinic and reception areas. Data provided by the trust showed that between January and May 2019, the average cleaning audit score for high and significant risk areas was 96.0%. Monthly environmental audits were also completed across the outpatient department. Data provided by the trust showed that between January and July 2019, the average environmental audit rating was 92.5% against 12 standards, which included clinical environments being clean and free of clutter. Two standards which were often recorded with poor scores related to the cleanliness and condition of furniture such as patient and visitor chairs.

There was no environmental audit completed in April 2019, with no reason given for it being missed. The outpatient action plan provided by the trust showed a responsible person would be allocated to ensure it was monitored and always completed.

Monthly hand hygiene audits were undertaken in all areas throughout the outpatient department. Following our inspection, we requested hand hygiene audit compliance data which showed that between January and July 2019, there was an average compliance of 86.1% based on 101 responses. Hand hygiene compliance showed a significant drop between January and March 2019, dropping from 91.7% in January to 70.0% in March. The compliance figure improved in following months, and was 100.0% in July 2019. Staff told us the recent improvement was due to increased numbers of staff trained in hand hygiene and audit.

Staff followed infection control principles including the use of personal protective equipment...
Staff received training about infection prevention and control (IPC) and hand hygiene during their initial induction and annual mandatory training. Following our inspection, data provided by the trust showed as of August 2019, 92.9% of nursing staff had completed this training. This met the trust target of 90%. We saw most staff using either hand gel or washing their hands at the appropriate time.

We saw staff follow infection control practices. This included wearing the correct personal protective equipment (PPE), such as gloves and aprons. We saw staff wearing gloves for all patient contact, and routinely sanitised their hands using either hand gel or handwashing facilities. Clinical staff adhered to the trust’s being bare below the elbows policy. This was in line with the National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from staff who wear gloves or decontaminate their hands immediately before and after every episode of direct contact or care. Handwashing facilities were appropriate and accessible. Hand hygiene gels were available for use at each entrance and exit to the department on all levels, and there was hand hygiene advice displayed on the walls, which reminded staff, visitors, and patients to decontaminate their hands prior to entry. Patients told us that staff washed their hands and used gloves before performing care.

Staff were aware of the procedures to follow if a patient had a communicable disease, such as tuberculosis or influenza. Where possible, appointments were booked for quieter working periods to reduce the risk of cross infection and minimise the time spent around other patients. Appropriate PPE, such as gloves and aprons, were readily available for staff to use. Staff could describe what they would do if a patient required isolation due to infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There were cleaning schedules in place throughout the department and we saw staff cleaning equipment at the start of the day and between patients. There was no evidence of high level dust. Some equipment was labelled as being clean using “I am clean” stickers, however, this was not consistent. Staff told us they would always clean equipment before and after use. Patients we spoke to stated that the department was always clean.

Disposable curtains were used to provide privacy around examination couches and in the waiting areas. They had been changed and dated in line with the trust’s infection control policy which stated curtains should be changed at a minimum every six months.

We saw a small number of children’s toys located in the reception area of the children’s outpatient department. The toys appeared clean, and we saw cleaning schedules were completed daily. However, there was one missed daily check in July 2019 and the department were unable to identify why the children’s area was not cleaned.

We observed a good decontamination process and defined cleaning pathway in place for flexible nasal endoscopes, which were fully compliant with the DH Health Technical Memorandum (HTM). Appropriate techniques were used to decontaminate the scopes in-between procedures, including ‘three part’ wipes used to decontaminate scopes used for invasive procedures. The scopes were decontaminated in a separate room from the clean scopes and then returned to a lockable cupboard where they were stored. We also saw training records which showed all staff had received the appropriate training on how to decontaminate the scopes appropriately. There was a contract in place with an external provider to ensure the scopes were properly maintained.

In the oral surgery and orthodontics department, all equipment was cleaned daily. Surgical procedure packs, and consumable items were stored in a tidy and organised manner. The department used a sterile service located at the trust’s main hospital site for decontamination and
sterilisation of surgical instruments. The equipment trays were well organised. Staff reported that they had good turnaround times and did not usually have any difficulties obtaining equipment.

**Environment and equipment**

The design and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, maintenance of equipment and the premises was not always completed.

Patients could reach call bells and staff responded quickly when called. There were emergency call alarms situated in consultation and treatment rooms across the outpatient department. Staff could use the emergency call alarms to summon urgent assistance as needed, such as when a patient deteriorated within the department. Emergency call alarms were also situated in the toilets, so that patients could summon urgent assistance if needed. There were clear pathways and processes for the assessment of people within outpatient clinics or who were unwell and required hospital admission. Staff were trained in life support techniques and had access to emergency resuscitation equipment. Resuscitation grab bags all contained adult and paediatric emergency equipment. Doctors were available within clinics to assist in the event of medical emergencies.

The design of the environment followed national guidance, however was not always well maintained. The hospital had been built and managed by an external contractor, they also provided repairs and maintenance of the environment. While the outpatient department was generally well maintained, during our inspection we saw long delays in repairs being completed. For example, a disabled toilet door in outpatient area A, had been reported as broken for over three weeks. Staff told us engineers had visited the department, however were unable to repair the door. We also reviewed monthly fire marshal audits and found that a seal on the outpatient main entrance fire door was reported in April 2019, which required replacement. The seal remained an issue and was recorded as still requiring replacement during the July 2019 audit. Staff told us that they had raised it at regular meetings with the contractor, however no action had been taken.

The outpatient department was built around a central courtyard garden, with most patient waiting areas facing on the courtyard, which provided natural light and views. There were large windows throughout and direct sunlight for most of the day, which made it a very hot environment in summer. Blinds were in place and windows were able to be opened, but staff told us it was still very hot for both staff and patients during the summer months. During our inspection, we found the outpatient department to be very hot, with consultation rooms facing direct sunlight to be an unpleasant environment. There was limited air conditioning throughout the building, staff used a small number of fans to try and keep areas cool. Prior to our inspection, the outpatient sister told us they had ordered a number of portable air conditioning units for a limited time which arrived while we were on site.

Outpatient reception areas were spacious and not cramped, which allowed patients to wait and register their arrival or make a follow up appointment in a pleasant environment. There were signs which indicated that patients should stand back from the reception desk to allow privacy of patients booking in, however this was not always noticed by patients and adhered to.

All consultation rooms had examination couches surrounded by disposable curtains, appropriate hand wash and hand sanitiser facilities, personal protective equipment dispensers, and chaperone posters on display. All consultation rooms we saw were lockable and were equipped...
with a desk and chairs. All hand wash sinks in the outpatient department were HBN compliant to allow correct hand hygiene.

Access to the paediatric clinics was limited to specific staff and was secured by a set of double doors, which were closed when patients were waiting for appointments. This prevented unauthorised access to the paediatric areas, and prevented children from leaving the department. A manned reception desk was located next to the waiting area doors to allow staff to monitor entry and exit.

The outpatient department had ‘hub rooms’ for use by staff when reviewing patient’s records and for clinic administration. Staff told us there would always be a member of staff in the room to prevent unauthorised entry and to ensure the patient records were kept secure when not used in consultation rooms.

Staff did not always carry out daily safety checks of specialist equipment. Emergency equipment such as a resuscitation grab bag and anaphylaxis box were located throughout the outpatient service, were in date and available to staff in a medical emergency. However, resuscitation equipment, for use in an emergency was not always checked daily as per trust policy. During our inspection we found 11 missed daily checks of portable oxygen cylinders and suction machines across the outpatient department between May and July 2019. In the breast clinic, we found three missed checks in May, and three in June 2019. In outpatient clinic area A, we found three missed checks in May one in June and one in July 2019. We raised our concerns with the outpatient sister who immediately reviewed why the checks had been missed and told us that staff had not completed them in line with trust policy. All staff across outpatients were reminded verbally to ensure checks were completed, and a reminded was recorded in communication books for staff not on shift.

The resuscitation grab bags were secured with non-tamper tags, which would alert staff if the bag had been opened. This would prompt staff to checks its contents to ensure it was safe to use. The resuscitation equipment was easily accessible, with two bags located on each level of the department. Fire extinguishers were visible and dated. Staff we spoke with explained the evacuation procedure and told us that they regularly attend fire prevention updates.

The service had suitable facilities to meet the needs of patient’s families. Unisex and disabled toilets were provided across the outpatient department, in addition to baby changing facilities and two baby feeding rooms. In consultation rooms, there was enough space for patients to be accompanied by friends and relatives.

The service had enough suitable equipment to help them to safely care for patients. Staff said they had sufficient equipment to meet patient’s needs, and there was usually no problems or delays in getting repairs completed. The maintenance and repair of patient equipment, the flexible nasal-endoscopes for example, was completed through contracts with external suppliers. An equipment servicing schedule and log book was in place and equipment was assessed annually as safe for use. A database was maintained to record the devices history and identify when equipment was due for servicing and maintenance. Data provided by the trust following our inspection, showed there were nine devices across the outpatient department which had past their annual review date. Six of the devices were last reviewed in May 2018, the remaining three were last reviewed in June 2017, May 2016 and one was last reviewed in December 2015.

Any equipment that needed repair was reported to estates and recorded on the incident reporting system. There were processes and procedures in place for externally maintained devices. Planned preventative maintenance and services of equipment within outpatient areas was carried out yearly.
During our inspection, all equipment we checked was within its expiry date and evidence of safety testing where appropriate. Equipment such as vital signs monitors, weighing scales etc, were labelled to indicate they had been maintained and calibrated in line with requirements. Staff in the outpatient service could demonstrate regular equipment checks were in place. Electrical equipment had been portable appliance tested, and all equipment observed was compliant.

Single use sterile instruments were stored appropriately and kept within their expiry dates. Surgical procedure packs, and consumable items were stored in a tidy and organised manner. The department used a sterile service located at the trust’s main hospital site for decontamination and sterilisation of surgical instruments. Disposable equipment and clinic room supplies, such as dressings, syringes, and plaster room supplies were stored appropriately, and all items inspected were found to be within their expiry date.

During our last inspection in October 2015, we found the ocular computed tomography (OCT) machine in the ophthalmology department was eight years old and had not been regularly serviced. The OCT machine recorded images across the eye. The trust confirmed that the machine was no longer supported, or software updated, or serviced by the manufacturer. We were therefore unable to confirm that the machine had recently been suitably serviced or calibrated. During this inspection, we found the OCT machine had recently been replaced and staff told us it was a noticeable improvement compared to the previous model. They said it was very quick at processing test results, and the consultants frequently requested to use it for their patients.

Staff disposed of clinical waste safely. Clinical waste was appropriately stored and disposed of in all clinical areas and there was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations’. Sharps bins were labelled, the bins were not overfilled and were closed when not in use. Control of substances hazardous to health (COSHH) risk assessments were in place to support staff’s exposure to hazardous substances. All COSHH chemicals were stored safely in locked cupboards.

**Assessing and responding to patient risk**

**Staff did not always complete and update risk assessments for each patient to eliminate or minimise risks. World Health Organisation safe surgery checklists were not used for invasive procedures in oral surgery and orthodontics. However, staff identified and quickly acted upon patients at risk of deterioration**

Staff responded promptly to any sudden deterioration in a patient’s health. The outpatient department had a clear pathway and process in place for the assessment of patients who became unwell within the outpatient service. A flow chart was displayed in the hub rooms for staff to refer to providing details of the procedure to follow if a patient became unwell in the department. Staff were familiar with the procedure, and in an emergency, staff called an ambulance and patients were transferred to the emergency department of an NHS hospital.

We saw emergency call bells were located throughout the outpatient department. These sounded an alarm when activated, which triggered a ‘crash’ response from staff across the department so that an unwell or deteriorating patient could receive prompt assistance.

Staff did not complete risk assessments for each patient when necessary. The outpatient department performed minor procedures in oral surgery and orthodontics clinics, however during our inspection we saw no evidence staff used the ‘Five steps to safer surgery’, World Health
Organisation (WHO) surgical safety checklist, which was not in line with National Patient Safety Agency (NPSA) guidelines. The WHO surgical safety checklist is used to reduce and potentially eliminate errors occurring during operations/procedures. Staff told us that they carried out a verbal team brief, confirmed consent forms and explained the procedure to the patient, however we saw no evidence staff followed the full briefing, sign-in, timeout, sign-out and debriefing process. We saw no evidence that verbal discussions were documented. We raised this with the outpatient sister and head of nursing for the division who told us a review of WHO surgical safety checklists was part of the safer surgery collaborative work which was in progress.

During the inspection, we asked if there were any local safety standards for invasive procedures (LocSSIPs) promote the effective performance of the five steps to safer surgery guidance. LocSSIPs are local policies designed to support hospitals to provide safer surgical care and to allocate responsibility for each clinical speciality that carried out procedures. Staff were unaware of LocSSIPs; however we were told that the department had standard operating procedures that were stored on the intranet. Following our inspection, the trust provided us with standard operating procedures for oral surgery minor operations and nasal endoscopy used in the ears, nose and throat (ENT) clinics. The outpatient sister and head of nursing told us there were no LocSSIPs across outpatients, however there was a plan to implement and review them as part of the safer surgery collaborative work. The lack of LocSSIPs was identified as a risk and is being reviewed by the outpatient board.

The outpatient department did not undertake any procedures under general anaesthesia/sedation. All local anaesthesia is administered by a consultant.

Staff knew about and dealt with any specific risk issues. Patients were required to complete a medical history questionnaire, which included the patient’s past medical history, known allergies, infection risks and details of medication they were taking. This information was reviewed to ensure potential risks were identified prior to treatment. We saw patients in the breast clinic completing medical history questionnaires, which were review by clinicians prior to their appointment.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they knew there was a mental health liaison team who could assess and support patients’ mental health.

Staff shared key information to keep patients safe when handing over their care to others and shift changes and handovers included all necessary key information to keep patients safe. Staff copied outpatient clinic letters to other professionals including colleagues involved in the care of patients, and to the patients’ GP to ensure key information was shared. Information was also shared across the department during multidisciplinary team (MDT) meetings and staff interactions during clinics. For example, clinical nurse specialists were based in the breast clinics and worked with doctors, pathologists and radiologists as part of a core team who attended weekly multidisciplinary team (MDT) meetings. Information was shared at these meetings as well as documented in the patients notes. Copies of clinic letters following patient’s appointments were sent to GPs to keep them informed of treatment plans and when patients had been discharged from services.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills,
training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. Data provided by the trust prior to the inspection, showed the staffing rate for nursing staff at Queen Elizabeth II Hospital was 91.0%. Staff told us that while established posts were generally filled, there were a small number of vacancies in some of the specialities. Nurse staffing levels across the service were appropriate to deliver safe care and treatment to patients. None of the staff we spoke with raised concerns about nursing staff levels, and the departments we visited were visibly calm and well managed during our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Nurse staffing requirements were devolved across the outpatient department, with most nursing staff provided by the clinical support services division, however individual specialities also planned and provided their own nursing staff to support their clinics. Staff said there was generally enough staff, with low numbers of vacancies and sickness. Staff were flexible and able to change shifts to maintain safe staffing levels on a day to day basis. In addition, bank staff from NHS professionals (NHSP) were used to cover shifts. NHSP is a company owned by the Department of Health to provide flexible worker services to the NHS.

We discussed the staffing requirements with the outpatient sister, as there are no national standards or guidelines for how outpatient clinics should be staffed. Across outpatient areas A and B, all outpatient nursing staff were recruited to work across both areas. This meant that staff could work across different areas, depending on the area of greatest need, which was identified by the outpatient sister when reviewing and planning nursing requirements. Staff from quieter clinics were moved to cover the busier clinics to ensure staffing levels were safe across the whole of the outpatient’s department. Staff working in the general outpatient areas had no concerns about staffing levels.

There were, however, staffing concerns in some of the clinical areas run by the specialities. Staff in ophthalmology told us that while staffing had improved, and the team had expanded, there was still a need for more staff due to the demand on the service, and the need to provide more clinic appointments. Breast clinic staff also shared this concern, who believed the demand for clinic appointments had outstripped the capacity and more nursing staff were required to deliver the service. Staff across the specialities were not aware of any plans to recruit and employ more staff to increase capacity.

The manager could adjust staffing levels daily according to the needs of patients and the number of nurses and healthcare assistants on all shifts matched the planned numbers. Staffing requirements were reviewed and planned six weeks in advance of clinic sessions and were amended as and when necessary. Staff told us that the team were flexible and changed their shifts to cover staff shortages. The outpatient sister told us there were no unfilled shifts across the department.

Managers limited their use of bank and agency staff and requested staff familiar with the service, and made sure all bank staff had a full induction and understood the service. The outpatient sister told us that the service did not use any agency staff, and the same bank staff were used regularly. All new staff, including NHSP staff, received a local induction to each area on their first shift. This ensured staff were familiar with departmental layouts and emergency procedures. This meant patients could be assured that staff were familiar with the service provided, the needs of
the patients and that staff had completed required training.

**The QEII Hospital**

From April 2018 to March 2019, the nursing staffing rate within outpatients at Queen Elizabeth Hospital was 91.0%. Nurse staffing rates within outpatients at the QEII Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and sickness.

The table below shows a summary of the nursing staffing metrics in services for outpatients at the QEII Hospital compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours</th>
<th>Annual agency hours</th>
<th>Annual unfilled hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>6%</td>
<td>10.5%</td>
<td>3.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>25</td>
<td>6%</td>
<td>14%</td>
<td>2.2%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>8</td>
<td>9%</td>
<td>20%</td>
<td>1.6%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The trust was unable to provide the total available hours in their bank and agency data. For this reason, we have been unable to calculate bank and agency usage as a percentage of available hours.

**Vacancy rates**

The service had low vacancy rates. Across general outpatients, the department had 41 hours of vacancy, split over two posts. The trust had been successful in appointing to both vacancies, with one nurse due to start in November, while the second had no confirmed start date as they were waiting for DBS and reference checks to be completed. In the oral surgery and orthodontics team there was one nursing vacancy, and in the paediatric outpatient team they had recruited to two new health care assistant posts.

**Medical staffing**

The trust did not report any medical staff working in outpatients at the QEII Hospital. Medical staff who worked in outpatients were associated to the various specialties and core services rather than the outpatient department, so this data was not collected or monitored by the outpatient department. Consultants and registrars were supported by clinical nurse specialists, nurses, health care assistants, and allied health professionals such as physiotherapists and dietitians. Staff told us there were generally enough medical staff, however in some specialties such as breast clinic, demand for outpatient appointments outstripped capacity.

**Records**

Patient records were not always and available to all staff providing care. Staff across the service reported records were often missing for clinic sessions. However, staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, and stored securely.
Patient notes were comprehensive, however not all staff could access them easily. During our previous inspection in October 2015, we found medical records were stored centrally off-site and were not always available for outpatient clinics. During this inspection, we found patient record availability remained an issue. While patients’ medical records were generally available for their clinic appointments, staff across the outpatient department and speciality clinics such as oral surgery and breast clinic told us that they frequently had concerns around missing records. Staff said on average patient records were missing prior to clinic sessions at least once a week. Records availability was also an issue for short notice ad-hoc clinic sessions which were organised, and patients booked two to three days prior to their appointment which allowed little time for records to be retrieved. Whether patients were seen without their medical record was dependent on the doctor who was leading the clinic, however staff told us that many doctors declined to see patients without their records. In oral surgery and orthodontics, minor operations had been cancelled due to records being unavailable.

We asked the trust for details of any record keeping audits, including patient record availability for outpatient clinics, however they told us that documentation audits were not routinely undertaken in the outpatient department. Following a review, the trust commenced an improvement project in June 2019, part of which included an ongoing audit of missing records and associated action plan to address any issues found. Staff reported missing records as incidents, however they did not receive feedback whether they had been located or not. After our inspection, the trust supplied us with data that demonstrated that from April 2019 to July 2019 records availability was being audited and records were generally available in at least 95% of all cases.

An established process was in place to mitigate risk if a patient attended an appointment and their medical record was not available. A temporary medical record was created along with an additional set of patient identification labels. Copies of referrals and medical history were obtained for first appointments from the GP or the referring hospital. For follow up patients, copies of clinic letters were provided. All available hospital correspondence was printed and filed in the temporary medical record. Clinical information including diagnostic and blood results were printed and filed in the temporary medical record.

The majority of records were paper based; however the trust recorded a range of information on its electronic patient record (EPR) system. Patient demographic details (such as name, date of birth and address), referrals and blood and diagnostic tests were stored electronically. Patient alerts were recorded in the EPR system using electronic flags, unique icons next to their name to highlight concerns. The flags highlighted a range of concerns including learning disability, domestic violence, social care involvement, non-English speaker, and looked after children. Safeguarding flags were recorded and updated manually on each patient’s record by the safeguarding team.

We reviewed six medical records and found they were hand written and legible.

The outpatients department communicated with GP’s via letter. According to the NHS Standard Contract, a clinic letter should be issued to the patient’s GP within seven calendar days following outpatient attendance (NHS England, Guidance on the NHS Standard Contract requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems (August 2018)). At the time of our inspection the trust did not monitor turnaround times for clinic letters to be issued to GPs.

When patients transferred to a new team, there were no delays in staff accessing their records. Records transferred to the health records library at the Queen Elizabeth II Hospital were readily available to all staff based on-site. If patients were seen at other hospital sites within the trust,
their notes would be sent to the relevant location and would have to be requested again if staff required access. Letters were sent to the patient’s GP following their clinic appointment, which included consultation details, their treatment plan and a discharge letter if relevant. These letters were also sent to the patient and other clinicians involved in their care. All staff with appropriate access could view patients’ demographic details, such as name, date of birth and address, scanned and electronic referral letters, and blood and imaging test results using the trusts’ EPR system.

Records were stored securely. Patients’ medical and nursing records were centrally stored off site and were regularly delivered to the Queen Elizabeth II Hospital. Patient records were initially stored in the health records library located on the first floor of the hospital and were then sent to the relevant area in preparation for outpatient clinics. Patient records were stored securely in crates behind locked doors in the health records library, or hub rooms located across the hospital. During our inspection we saw doors to the health records library and hub rooms were propped open, however there was always a member of staff in each room to prevent unauthorised entry. Staff told us the doors would be shut and the rooms looked when not in use. No notes were stored in consulting rooms.

During our inspection, we saw no patient identifiable data (PID) was left unattended or in public view and computers were locked when not in use. Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual account log-in details.

**Medicines**

The service used systems and processes to safely prescribe, administer and record medicines. However, the service did not always store medicines safely. Ambient room temperature checks were not recorded or monitored in areas where drugs were stored.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Nursing staff told us they were aware of policies on administration of medicines as per the Nursing and Midwifery Council Standards for Medicine Management. They were also aware of the trust’s medicines policy, which outlined suitable arrangements for the recording, safe-keeping, handling and disposal of medicines. Staff were aware of how to find the policy on the trust’s intranet, They were able to describe processes for monitoring stock levels of medicines stored in cupboards and ensuring that all stock was within its expiry date.

Nursing staff were able to administer medicines against a patient group direction (PGD). PGD’s are written instructions which allow healthcare professionals who are not prescribers to supply or administer medicines to defined groups of patients. This meant they could offer simple pain relief, for example, paracetamol and other medicines to patients without waiting for a doctor to write a prescription.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Patients told us their medicines had been explained to them along with the possible side effects, and doctors reviewed their medicines on a regular basis.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy, however ambient temperature checks were not performed in areas where medication was stored. The outpatients service had appropriate lockable storage facilities for medicines, such as cupboards and fridges. Keys to the medicine cupboards were stored in accordance with national guidance and held by nursing staff to prevent unauthorised staff from gaining access. Medicines
which needed to be kept within a certain temperature range were stored in locked fridges. Medicines’ management regulations stated minimum and maximum temperatures of locked medicine refrigerators, and these ranges were displayed on the temperature monitoring forms. Nursing staff were responsible for monitoring fridge temperatures. We reviewed fridge temperature checks across the outpatient department between May and July 2019 and found that fridge temperatures had been checked daily. There was one occasion in July 2019 in the breast clinic clean utility room where an out of range fridge temperature was recorded. The fridge was measured outside of range in the morning and staff told us they were unsure how long the fridge had not been at the correct temperature as it was only checked once a day. The fridge was reset and checked every 30 minutes however staff were unable to say how quickly it returned to range, and were unsure if it had been reported as an incident, however they told us that they would escalate to pharmacy.

During our inspection we reviewed ambient temperatures of the clean utility rooms where medications were stored and found that staff did not record or check ambient temperatures. We raised our concerns with the outpatient sister who told us they were aware it was an issue and had already requested a log book to begin recording ambient temperatures. The head of nursing for outpatient’s told us that there was a process in place and if temperatures exceed 30 degrees for three consecutive days, pharmacy would be notified and the shelf lives of medication would be reviewed and reduced accordingly. However, we were not assured appropriate processes were in place as the department was not recording ambient room temperatures, and therefore was unable to record if temperatures were above 30 degrees for three consecutive days.

We found no controlled drugs (CDs) being stored or administered within the outpatient’s service.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff told us the pharmacy team visited the outpatient on a regular basis, and safety alerts and incidents were shared with the nursing team. Pharmacy updates were included in the clinical support service quality and safety newsletter, which was shared with the outpatient nursing team.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff throughout the outpatient department described the process for reporting incidents and were confident in using the system.

Staff reported all incidents that they should report. Staff told us they were aware of what constituted an incident, and the types of issues they should report and record as incidents. For example, staff said when patients’ notes were unavailable or missing for clinic appointments, they would raise an incident.

Never Events
The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2018 to May 2019, the trust reported no incidents that were classified as a never event for outpatients. *(Source: Strategic Executive Information System (STEIS))*

Managers shared learning with their staff about never events that happened elsewhere. Staff when asked, could give examples of never events that had happened at other trust sites, which had been shared during team meetings and daily huddles.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

**Trust level**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from June 2018 to May 2019. One of the incidents was classified as a treatment delay meeting SI criteria and the other was classified as a diagnostic incident including delay meeting SI criteria (including failure to act on test results). While these incidents were reported to STEIS under the location ‘outpatients’, they had occurred within specific medical specialities and/or departments and were investigated accordingly by the relevant specialties. We reviewed the incident reports and found comprehensive investigations were completed, with lessons learned, arrangements for shared learning, recommendations and actions taken to minimise the risk of recurrence. *(Source: Strategic Executive Information System (STEIS))*

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation. 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.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff team meetings, daily huddles, divisional newsletters and on staff noticeboards. During team meetings and huddles, improvements were discussed and learning shared.

There was evidence that changes had been made as a result of feedback. Following learning from incidents, call bells had been installed across the consulting rooms to increase patient safety and ensure assistance could be summoned in an emergency.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed root cause analysis of a serious incident and found comprehensive
investigations were completed, with lessons learned and arrangements for shared learning. We saw evidence of action plans put in place to reduce recurrence, and discussions with patients and their families who were invited to discuss the outcome of the investigation.

Managers debriefed and supported staff after any serious incident. Staff told us when they had reported an incident, they discussed it with their manager and when feedback was returned they had further discussions about what improvements could be made to prevent it from recurring.

**Safety thermometer**

*The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.*

The service continually monitored safety performance. Staff collected safety information and shared it with staff, patients and visitors. The NHS Safety Thermometer is a national tool 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. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. The trust reported outpatient monthly RTT performance levels and did not attend rates across the outpatient department. The trust also reported the number of harm reviews completed and identified the number of cases that had led to patient harm.

**Is the service effective?**

**Evidence-based care and treatment**

*The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.*

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff across the service had up to date policies and guidance in place which were stored and available on the trust’s intranet. Policies we reviewed referenced up to date relevant national guideline and best practice and had been assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. For example, local policies such as the resuscitation policy were written in line with national guidelines. Clinical pathways and proformas were standardised across the clinical services division and outpatients, to ensure patients were assessed systematically in line with best practice. Specialities across the outpatient department delivered care and treatment in line with National Institute for Health and Care Excellence (NICE) guidance and from other professional associations. For example, staff in the gynaecology clinic had access to NICE guidelines NG73, and in the pre-operative assessment clinic, staff 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. Staff told us they followed national and local guidelines and standards to ensure effective and safe care.

Staff told us they were kept up to date with changes in policies by the outpatient sister at team meetings. Staff we spoke to across the outpatient department had a good awareness of and had read local policies. They could give us examples of how to find policies and when they had used them.

We saw that the service monitored compliance against National Institute for Health and Care...
Excellence (NICE) guidelines and took steps to improve compliance where further actions had been identified. The trust provided us with examples of completed gap analysis action plans (GAAP) which were used to measure, monitor and assess actions and risks associated with national audits and NICE guidance. The GAAPs were reported to a sub board of the trust board, to ensure all policies were updated when required and guidance published relevant to the service were fully compliant.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with were aware of the requirements.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs. Patients had access to dietary advice when needed.**

Staff made sure patients were able to eat and drink, including those with specialist nutrition and hydration needs. While patients attending the department were not routinely provided with food or drinks, as they were only there for a short period, access was provided by a café based on the ground floor of the hospital. There were also water coolers and disposable cups available throughout the department. Staff were alert to patient’s hydration needs and we saw staff providing patients with water while they waited if required.

Patients who attended for invasive investigations were advised on whether they could eat or drink prior to their appointment. We saw patient letters which detailed any restrictions for the investigation.

Specialist support from staff such as dieticians was available for patients who needed it. There was access to specialist dietary and nutritional support in some clinics such as oncology and the head and neck clinic. Nursing staff were able to contact dieticians and speech and language therapists who could visit patients in the head and neck clinic to provide advice and support on eating, drinking and swallowing.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief when needed. They supported those unable to communicate using suitable assessment tools.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a numeric or visual analogue rating scale and assessment scoring tool to help patients describe their pain. There was a multidisciplinary pain management clinic led by a consultant, and involved specialist pain nurses. Breast clinic staff carried out pre-assessment checks and assessed pain relief for patients undergoing procedures such as biopsies through pain assessment criteria.

Staff prescribed, administered and recorded pain relief accurately. Pain relief was not routinely used in the outpatient department, except for when patients were attending for invasive procedures such as in oral surgery and orthodontics. Patients undergoing procedures were asked to score their pain to identify whether additional pain control was required. Staff told us that some patients were advised that procedures may be uncomfortable, and time was taken to reassure the patients and keep them informed of the length of time remaining for procedures. In oral surgery staff provided patients with pain control specific to the procedure being undertaken. When patients...
underwent surgical procedures, we saw that local analgesia was used and patients monitored for pain and discomfort throughout the procedure.

**Patient outcomes**

**Staff generally monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The outpatients’ service did not generally participate in local or national clinical audits. These were undertaken by medical and surgical specialities. Most specialities participated in national clinical audits, such as the Vascular Services Quality Improvement Programme (VSQIP), National Bowel Cancer Audit and National Prostate Audit.

Managers did not carry out a comprehensive audit programme, however they audited outpatient performance measures that impacted on patient experience and outcomes. For example, hand hygiene and the environment. During our inspection, we saw audit results which showed that between January and July 2019, there was an average compliance of 86.1% with standards for the hand hygiene audit which was based on 101 responses. In July 2019 the compliance figure was 100%, staff told us the recent improvement was due to increased numbers of staff trained in hand hygiene and audit.

Managers used information from the audits to improve care and treatment, and they shared and made sure staff understood information from the audits. Improvement was checked and monitored. The trust produced monthly performance dashboards which included several indicators such as the number of patients who ‘did not attend’ (DNA), the number of unused appointment slots, the trust cancellation rate and the discharge rate. Measures such as referral to treatment times and other performance dashboard indicators were discussed at clinical governance and operational meetings and ways in which they could be improved were discussed. Managers shared audit results and improvements discussed at governance meetings with staff and they were discussed at regular team meetings.

**Follow-up to new rate**

From February 2018 to January 2019 the follow-up to new rate for Queen Elizabeth II Hospital was similar to the England average.

**Follow-up to new rate, East and North Hertfordshire NHS Trust.**
Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

**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 and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff confirmed they had been assessed to ensure they were competent in their role. We saw a competency folder in place which demonstrated staff had been appropriately assessed. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education by their manager. Nursing staff within the outpatient department had undertaken some form of communications training and some of the registered nurses had undertaken advanced communication skills training.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us they received a comprehensive and structured induction when they commenced work at the trust. This included a trust wide induction and local induction. The trust wide induction took place over five days and covered mandatory training modules including information governance, fire safety and infection prevention. New staff were supported to complete a local induction and familiarisation checklist, which included orientation to the area, such as a tour of the unit, fire evacuation routes and resuscitation grab bag locations. They were also required to read a familiarisation document for the hospital and become accustomed with local processes, policies and procedures. New staff were expected to complete competency assessments and we saw evidence of new staff having completed these in recent months. For example, we saw evidence of recently completed competency assessments for aseptic technique, hand hygiene and decontamination of insufflates and light sources. The trust used regular bank staff to fill shifts. All bank staff had an induction and were orientated to the clinical areas to ensure that they were familiar with procedures and the environment. Managers generally used the same bank nurses whenever possible.
Appraisal rates

The QEII Hospital

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received an annual appraisal which they told us was constructive and provided a formal opportunity to review their progress and identify further training needs. Data provided by the trust prior to the inspection showed that the 90.0% target was met for two of the four staff groups in outpatients. Appraisal rates for nursing and midwifery staff were 83.3%. From April 2018 to March 2019, 92.6% of staff within outpatients at the QEII Hospital received an appraisal compared to a trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>11</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>8</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

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

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff told us they were encouraged to attend training courses and were given to attend them. Nursing staff said they had access to supervision and were always encouraged to develop their skills. During our inspection, we spoke to nursing associate practitioners from local universities who were on placement across the outpatient department. They told us they were assigned a mentor from within the team and were supported to develop their skills and complete a competency booklet. The associate practitioners said medical staff had been very supportive and were always happy to answer questions and share their expertise.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings for nursing staff were held every two weeks which were chaired by the senior staff nurse for outpatients. They did not have a set agenda, however often covered topics including complaints, training compliance, and incidents. The outpatient sister told us they try to attend team meetings as frequently as possible to deliver key messages from divisional managers. Reception staff said they had team meetings three to four times a year. The oral surgery and orthodontics team had monthly team meeting on audit days.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff told us their training and development needs were discussed at their annual appraisal and were given the opportunity to attend training courses relevant to their role. The outpatient department had a range of specialist and link nurses to support staff in clinical areas. For example, there were link nurses for dementia, infection control, hand hygiene, learning disabilities and fire safety. This meant that staff had access to specialist support and could ask for advice if required.
Managers identified poor staff performance promptly and supported staff to improve. At the time of our inspection, there were no staff who with performance issues which had been identified.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw that care was delivered in a coordinated way and that staff in different teams were involved in providing person centred care. There was evidence of staff working together to meet patients’ needs. Physiotherapy and occupational therapy staff worked with nursing and medical staff in the trauma and orthopaedic and rheumatology clinics to provide holistic care. In the head and neck and oncology clinics, dieticians and speech and language therapists worked with nursing and medical staff to improve patients care. Clinical nurse specialists worked in the breast clinics and provided care for patients having treatment for breast cancer. They worked with doctors, pathologists and radiologists as part of a core team who attended weekly multidisciplinary team (MDT) meetings. Following MDT meetings, the clinical nurse specialists ran telephone clinics to update patients on their treatment plan following discussion at the MDT meeting. Copies of clinic letters following patients’ appointments were sent to GPs to keep them informed of treatment plans and when patients had been discharged from services.

Patients could see all the health professionals involved in their care at one-stop clinics. The trust provided one stop clinics, where possible, to reduce the number of appointments. For example, patients attending for a review of an orthopaedic procedure had their x-ray and consultant appointment at the same time if possible, preventing patients from attending the hospital on two separate occasions. Patients who were classed as urgent based on agreed local criteria such as patients with suspected or diagnosed cancer were seen in a ‘one stop’ pre-operative assessment clinic. In the breast clinic, clinical nurse specialists were regularly involved in clinics alongside medical staff. Patients were able to have some diagnostic tests within the department on the same day as a consultant appointment.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the department. We observed good collaborative working and communication amongst all members of the service. Staff reported that they worked well as a team.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

**Seven-day services**

**Key services were available seven days a week to support timely patient care through referrals to inpatient services. However, outpatient clinics were not available seven days a week.**

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. These were available when necessary, with doctors able to refer for diagnostic tests such as plain film radiography (x-ray) and computerised tomography (CT) scans, which were offered on site. Outpatient clinics were held Monday to Friday from 8.30am to
5.30pm. There were no outpatient clinics provided on weekends. Consultants told us they had suggested running extra clinics in the evenings and at weekends to increase capacity and reduce waiting lists, however this offer had not been accepted and there were no long-term plans to work towards seven-day services within outpatients.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support in patient areas. Across the outpatient department we saw a range of health information and advice leaflets and posters which were relevant to clinic specialties. For example, in the breast clinics there was a range of breast cancer support leaflets and contact details of relevant cancer care charities that may be able to offer support and advice to patients, which offered both psychological and financial support. In the Outpatient B clinics, there was a range of leaflets and information for gynaecology and antenatal patients including information on endometriosis, and procedures such as transvaginal ultrasounds and mid-urethral slings.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients during consultations. In the pre-assessment clinic, patients told us that during appointments nurses discussed general health promotion and gave advice. For example, advice was offered on smoking cessation prior to surgery and ways to cut down. The pre-assessment team also referred patients to dieticians and physiotherapists if they required assistance with eating a healthy diet and increasing their physical activity. Patients who attended breast clinics were reviewed by clinical nurse specialists throughout their visits to the department and provided advice and support to maintain their health during treatments and following treatment.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, consent was not always documented in patients records.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to had a good understanding of the need to assess patient’s capacity to make decisions when necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us that formal consent was not obtained for outpatient interactions and examinations which did not involve invasive procedures, as when patients attended the outpatient department for treatment they gave implied consent. Patients told us that staff explained any examinations to them, and we observed patients complying with requests to be examined. Patients told us they were given full explanations by staff, including the risks and benefits of proceeding with treatment. For most invasive procedures, formal documented consent was obtained and recorded in the patients’ records.

When patients could not give consent, staff made decisions in their best interest, taking into
account patients’ wishes, culture and traditions. Staff were able to explain the best interests’ decision-making process. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability or were living with dementia. Staff told us they involved the patient’s relatives and carers to provide further information about the patient’s wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient.

Staff made sure patients consented to treatment based on all the information available. Patients told us they had been given clear information about the benefits and risks of their procedure or treatment plan in a way they could understand prior to signing the consent form. Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

Staff did not always record consent in the patients’ records. For most invasive procedures, such as biopsies, injections and minor surgical procedures, staff told us they obtained formal written consent. However, prior to patients undergoing flexible naso endoscopy procedures, we saw no formal consent documented or evidence of verbal consent discussions documented in the patients’ records. Staff told us that patients gave implied consent and that clinicians would obtain verbal consent prior to carrying out the procedure. Across other specialities in the outpatient department such as gynaecology, gastroenterology and dental, we saw documented consent forms across were used for a range of invasive procedures and we saw evidence of these in the patients’ records. This was in line with the World Health Organisation (WHO) guidelines for safe surgery. We asked the trust for evidence of any consent audits, but they were unable to provide this as they did not routinely complete consent audits in outpatient services, however speciality consent audits were part of the forward audit plan for 2019/20.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Staff we spoke to in areas that saw children under 16 were able to describe the principles of Gillick competence, which is concerned with determining a child’s capacity to consent. It is used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

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

**The QEII Hospital**

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust had two training modules for nursing staff which were mandatory and had set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. The trust has stated that MCA and DoLS training was delivered as part of the adult safeguarding module. Data provided by the trust prior to the inspection showed that the 90% target was met for all the mandatory training modules for which registered nurses at the QEII Hospital outpatient department were eligible. Across both modules, the data provided showed an overall compliance of 100% for nursing staff in outpatients.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at the QEII Hospital for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1 - 2 Years</td>
<td>9</td>
</tr>
</tbody>
</table>
Safeguarding Adults Level 2 - 2
Years

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

The trust did not report any medical staff working in outpatients at the QEII Hospital. Medical staff were not directly employed by the outpatients’ department, therefore training requirements were the responsibility of the clinical speciality.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Medical and staff supported patients to make decisions in line with relevant legislation and guidance. Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards which were available on the trust’s intranet.

Managers did not monitor how well the service followed the Mental Capacity Act.
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff being caring and compassionate with patients and their relatives. Patients praised staff for their kindness and understanding of their needs. Staff treated patients with dignity and respect and spoke in a respectful and friendly manner. Staff members spent time with patients and interacted with them during tasks and clinical interventions. The department had a chaperone policy. There were posters available informing patients about the availability of chaperones and staff were readily available to act as chaperones when needed. All patients were offered the choice of having a chaperone during their consultations.

Patients said staff treated them well and with kindness. Patients told us all staff, including nurses, doctors and receptionists were very pleasant, and treated them with great kindness. We observed caring interactions with patients whilst they were booking in at the main reception or being assisted across the department. Patients were welcomed into the hospital, and staff introduced themselves to patients, explained their role what would happen during the consultation, including any minor procedures. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

Staff generally followed policy to keep patient care and treatment confidential. Clinicians closed consulting room doors during patient care to protect the privacy and dignity of patients. Staff used signs to confirm when a treatment or consulting room was ‘in use’, and we saw that staff knocked and asked permission before entering a room. However, when patients were having their blood taken in the blood test department, staff did not draw curtains around cubicles. Several cubicles were positioned facing each other on either side of a corridor, and patients faced each other when having their blood taken. There were signs which indicated that patients should stand back from the reception desk to allow privacy of patients booking in as reception areas were spacious and in an open environment. However, this was not always noticed by patients and adhered to, so staff offered patients a private room to discuss sensitive information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff responded well to people’s questions and concerns. Staff quickly recognised when someone might need some extra reassurance or support and provided it tactfully. Staff were aware of how patients’ behaviour may be affected by their health and showed compassion and understanding during their interactions.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. However, staff in the breast clinic found it difficult to support distressed patients due to a shortage of private quiet rooms.
Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided emotional support to patients to minimise their distress. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display difficult behaviours during their visit to outpatients. Patients attending the breast clinic were accompanied by clinical nurse specialists, when they had to give distressing news, to allow the nurses to provide immediate emotional support and comfort patients in distress. Patients told us staff were very helpful, and were able to answer any questions they had, without feeling rushed. There was a range of information available for patients to take away across the outpatient department in the form of booklets and leaflets. In the breast clinic we saw leaflets on care and support for living with cancer, diet and breast cancer, and understanding your pathology results.

Staff generally supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. However, staff in the breast clinic struggled to find a private area when supporting distressed patients. Staff told us when the hospital first opened, the breast clinic had access to a private quiet room for use when delivering distressing and emotionally upsetting news. Access to the private room was lost following a review of the working environment and rooms used by the radiographers and radiologists who also operated from the breast clinic. The diagnostics staff were unable to work effectively in the rooms they were allocated and required the use of the quiet room to continue to provide the service to a high standard. Staff said due to the lack of dedicated quiet room, there had been times when they had escorted distressed and upset patients around the department looking for a spare room. However, they have never received any complaints from patients in relation to this issue. Staff had submitted a proposal to convert a storage cupboard into a small quiet room, however the proposal had not been accepted as it would have required remedial work to install a frosted glass door to allow natural light into the room. Following our inspection, the trust told us that they recognised the current facilities did not meet expectations, and senior managers would work with staff to improve this. Across the rest of the outpatient department, staff delivered distressing news in a private environment that was suitable, and ensured that patients had enough time to processes and ask questions without being disturbed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Nursing staff within the outpatient department had undertaken communications and compassionate care training and some of the registered nurses had undertaken advanced communication skills training. All patients we spoke to said nursing and medical staff discussed sensitive issues with empathy and compassion.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff provided emotional support whilst caring for patients and were allowed time to provide any level of support that was required. Staff also offered practical advice on benefits and financial assistance. We saw that staff were kind and smiled during appointments, in order to reassure patients.

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

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff involved patients and those close to them in decisions about their
care and treatment. Patients we spoke to said they felt involved, and had been given the
topportunity to ask questions, and felt comfortable and reassured. All patients told us they were
provided with a good, clear explanation and were provided with written information about their
condition. Patients told us they had had been kept ‘well-informed’ of the treatment plan and that
they felt able to raise any concerns with the consultant. All patients we spoke with could explain
what they had been told during their consultation, and they had received all relevant information
during their pre-assessment appointment. Patients were provided with a range of information
booklets during their appointments, in addition to verbal information given to them by staff.
Patients received a copy of the letters sent to their GP following their outpatient appointments.

Patients and their families could give feedback on the service and their treatment and staff
supported them to do this. Staff encouraged patients to give feedback through satisfaction
questionnaires, and we observed patients being given leaflets following their appointment. Copies
were also available in waiting areas across the outpatient department. The trust provided
information about a range of surveys and the results from these.

Staff supported patients to make informed decisions about their care. Patients told us they were
very satisfied with the care they received and the staff who provided it. Patients told us, they had
been involved in how and where, their ongoing treatment took place. They said they had plenty of
opportunity to ask questions and staff listened to them and were happy to answer any questions
they had.Patients told us they had had been kept ‘well-informed’ of their treatment plan and that
they felt able to raise any concerns with the consultant. Staff checked patient’s understanding prior
to asking them to make decisions.

The feedback from the Friends and Family Test was positive for all areas. All patients had the
opportunity to complete the NHS Friends and Family Test (FFT) and indicate their likelihood to
recommend the service. The Friends and Family Test (FFT) is an important feedback tool that
supported the fundamental principle that people who use NHS services should have the
opportunity to provide feedback on their experience. In March 2019, 669 patients responded to the
FFT (Source: DR185). Of these, 74% of patients said they would be ‘extremely likely’, and a
further 22% ‘likely’ to recommend the outpatient service. The remaining were ‘neither likely or
unlikely (1.5%), ‘unlikely’(0.6%) or ‘extremely unlikely’(1%) to recommend the service.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the
communities served. It also worked with others in the wider system and local
organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.
Outpatient clinics were provided at the Lister, Queen Elizabeth II (QEI) and Hertford County
Hospitals and Mount Vernon Cancer Centre. This meant patients could be seen closer to their
home if the clinical specialty and capacity allowed. Patients could select where they were seen
using the NHS e-referral system. The outpatient department at the Queen Elizabeth II Hospital
offered appointments for a wide range of specialties to meet the needs of the local population.
These included breast clinic, cardiology, colorectal, dental, ears, ENT (ears, nose and throat),
fracture clinic/orthopaedics, gynaecology, paediatrics, plastic surgery, pre-operative assessment,
rheumatology, and urology. The phlebotomy/blood test team also carried out home visits to
patients unable to travel and access services at the hospital.
The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients were able to attend one stop clinics for some specialties which enabled them to have diagnostic tests and consultations at the same appointment, reducing the need for further visits. For example, patients attending for a review of an orthopaedic procedure had their x-ray and consultant appointment at the same time if possible. Patients were also able to have blood tests and clinical measurements taken such as weight, height and heart tracings (ECGs) during their visit to the hospital.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All patients seen across the outpatient department were seen in individual consulting rooms and were only required to undress while in the consulting room.

Facilities and premises were appropriate for the services being delivered. The outpatient department had appropriate facilities to meet the needs of patients awaiting appointments. The outpatient department had eight reception and waiting areas split across three floors, which were all in use and manned during our inspection. There was a separate waiting area for paediatric patients. There was sufficient seating in waiting areas which were comfortable and had access to water dispensers and reading material. The waiting areas provided wheelchair accessible bathrooms, which were clean and checked regularly. Baby changing facilities and a nursing room were also provided. There were sufficient unisex toilets within the service for use by male and female visitors, which were clean and regularly checked. Baby changing, and a nursing room were also provided. There was access to cold refreshments. All consulting rooms were appropriate the assessment and treatment carried out and provided privacy and dignity to patients.

Signage throughout the outpatient department was clear, visible, and easy to follow. Each outpatient department/speciality was clearly signposted, and volunteers were situated in the main hospital entrance and offered patient’s individual assistance to find a particular clinic if required. Access to waiting areas and outpatient consulting rooms on all three floors could be reached by both stairs and a lift available for use by patients. The number of clinics rooms was mostly sufficient to accommodate the number of clinicians seeing patients. In the paediatric clinic, staff told us there had been occasions when there were more clinicians working in the clinic than there were consulting rooms for them to see patients, however this happened rarely. When this occurred, managers tried to make alternative arrangements within the department.

Information was provided to patients prior to their first appointment and contained information required by the patient such as contact details, information about the procedure if appropriate and address. Car parking facilities were available at the Queen Elizabeth Hospital, with plenty of parking bays to meet demand. When asked about parking, patients were happy with the provision at the hospital.

Staff could access emergency mental health support 24 hours a day 5 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they knew there was a mental health liaison team who could assess and support patients’ mental health. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff checked patients in the waiting room regularly and identified those in need of additional support or intervention and responded to any needs they may have. Volunteers were available at the outpatient reception to guide and accompany patients to the different departments. Volunteers told us they had learned to recognise those patients who were unfamiliar with the area and might need additional support.
Did not attend rate

From February 2018 to January 2019 the did not attend rate for Queen Elizabeth II Hospital was higher than the England average from February to June 2018. From July 2018 to January 2019, the rate was similar to the England average.

The chart below shows the did not attend rate over time.

Proportion of patients who did not attend appointment, East and North Hertfordshire NHS Trust

![Graph showing did not attend rate over time]

(Source: Hospital Episode Statistics)

Spells that have been assigned to the site name “East and North Hertfordshire NHS Trust” are those that have not been assigned to a specific site in the data.

Managers monitored and took action to minimise missed appointments. Patients who did not attend (DNA) appointments were monitored and recorded on the trust’s patient administration system (PAS). The trust had implemented a text reminder messaging service which prompted patients of their next appointment date, however staff told us this relied on patients providing the correct contact telephone numbers and informing the hospital of any changes which did not always happen. If patients required a follow up appointment, they were sent a clinic letter in post informing them of their next appointment date and time. Patients were able to contact the bookings team via telephone and amend their appointment time and date if necessary, and staff tried to accommodate changes whenever possible. Patients we spoke to said they had no problems when choosing appointment slots, and the hospital were flexible in allowing them to choose times and dates that suited them.

Managers ensured that patients who did not attend appointments were contacted. The department monitored patients who did not attend (DNA) their appointments. They were contacted and offered the earliest available appointment, or one which was suitable to them. If a patient did not attend two consecutive appointment offers, they were either referred back to their GP, for re-referral if appropriate, or their referrer was contacted to encourage them to ensure the patient attended.

The service relieved pressure on other departments when they could treat patients in a day. Patients were able to have blood tests or other investigations on the same day as their outpatient appointment, in order to reduce visits for the patients and relieve pressure on other services.

Meeting people’s individual needs
The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The outpatient department had link nurses for learning disabilities and dementia, who had attended additional training and supported staff throughout the department. Staff told us they had tried to reduce waiting times for patients with complex needs and the booking team aimed to allocate earlier appointments to reduce the risk of patients becoming anxious or distressed, in noisy, crowded environments. Patients with complex needs were recorded on the trust’s electronic patient record (EPR) system using an electronic flag to enable to booking team to identify them.

The department was accessible to patients with a physical disability. Access to waiting areas and outpatient consulting rooms on all three floors could be reached by a lift which was available for use by patients. All consulting rooms and waiting areas were accessible to wheelchair users.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. There was a learning disability link nurse working within the outpatient department, who supported the team and were able to share their expertise across the department. Staff told us they used the ‘this is me’ documents and patient passports when patients attended the department.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There were hearing loops (a sound system available to assist patient’s wearing a hearing aid) available at each of the outpatient and main hospital reception areas. Information leaflets were available in accessible formats, including large print, braille, audio or sign language (videos) if they were requested.

The service had information leaflets available in languages spoken by the patients and local community. The service provided a range of patient information leaflets, and patients were given a wide range of information during consultations. Information on conditions, surgical procedures and treatments were also available. We found the information leaflets were all current and relevant. Information was available in accessible formats.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service provided appropriate translation services, and sign language interpreters, when required. Translation services were available through a private contracted service. This included British Sign Language as well as other spoken languages. The outpatient department had access to a telephone interpreter if they could not attend the hospital at short notice. Staff told us they had experience any difficulties with accessing interpreters when they were needed.

Access and flow

There were frequent delays in the running of clinics and staff felt pressured to meet the demands of the service due to long waiting lists. While most people could access the service when they needed it, waiting times for cancer patients to start treatment were lower than the England average. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally in line with national standards.
There were frequently delays in the running of outpatient clinics, and staff across the department felt pressured due to the volume of patients who required an appointment. However, managers monitored waiting times to ensure patients could access services when needed and received treatment within agreed timeframes and national targets. During our inspection, we found clinics regularly over-ran and some patients had to wait a long time to be seen. All reception areas across the outpatient department displayed patient waiting times and we saw that this was updated regularly. Throughout our inspection, we saw patients often experienced waits to be seen beyond their appointment time. Staff told us some patients attending clinic experienced waits of over an hour, and in some cases, there were two hour delays. Delays in the running of clinics were displayed on notice boards within each area, and we also spoke to staff to understand waiting times for patients. The average wait across the outpatient department was 15 to 30 minutes, however in some areas it was longer. Patients we spoke with gave variable feedback about delays to appointments. Some patients said they had no wait and were seen in clinic as soon as they arrived, while others told us of waits of up to two hours. Delays in clinic were one of the main themes from the patient experience surveys.

A breakdown of observed delays in clinical areas noted during our inspection at the QEII Hospital is shown below:

<table>
<thead>
<tr>
<th>Clinic Area</th>
<th>Date of Clinic and Delay (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24 July 2019</td>
</tr>
<tr>
<td>Breast</td>
<td>15 – 30</td>
</tr>
<tr>
<td>Oral Surgery and Orthodontics</td>
<td>15 – 30</td>
</tr>
<tr>
<td>Outpatient A</td>
<td>15 – 30</td>
</tr>
<tr>
<td>Outpatient B</td>
<td>30 – 60</td>
</tr>
<tr>
<td>Radiology and Fracture</td>
<td>15 – 30</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>No delay</td>
</tr>
</tbody>
</table>

All staff we spoke to across the outpatient department said delays in clinic were due to the limited capacity of clinics, with patients frequently overbooked on clinic sessions. In the breast clinic, nursing and medical staff were concerned about the number of patients they were booked to see in the clinics. Clinicians told us the number of clinic sessions had increased, and the number of patients to be reviewed within the same time had also increased. In some breast clinic sessions, clinicians were expected to review patients within 10 to 15 appointment slots. This included reviewing new patients, discussing test and imaging results, and potentially breaking distressing news. As a result, clinics often ran late as staff ensured patients received the best experience by ensuring patients got the time they required. Both nursing and medical staff had frequently raised this with divisional managers and had suggested evening and weekend clinics to reduce the numbers seen in clinic sessions, but maintaining the volumes of patients seen each week. However, they reported they had met with resistance and limited engagement from divisional managers.

In other specialities, staff were concerned around the length of appointment slots which did not allow for a pleasant patient experience and caused clinics to run late. For example, in fracture clinic staff told us they were required to see patients within a 10 minute appointment slot, which they did not feel was appropriate given the acuity of patients booked into the clinic. Staff said they reviewed frail, partially sighted and hard of hearing patients who required 10 minutes to settle into the consulting room and begin to answer questions. The trust told us that a virtual fracture clinic was opened during our inspection to help manage demand in outpatient services across the trust.
The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publicly 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. During our last inspection in October 2015, we found that patients were able to access the majority of outpatient services in a timely way for initial assessments or treatment. However, in September 2017 the trust stopped reporting its performance against the RTT target due to data reporting issues caused by the electronic patient record (EPR) implementation. The trust resumed national RTT reporting in September 2018.

There was a trust wide approach to managing RTTs across all the main hospital sites. The RTT management process was described within the trust’s patient access policy. Each clinical speciality was responsible for their patient waiting lists and their RTT performance. This was managed by the individual directorate or specialty managers who were responsible for monitoring the patient tracking lists (PTL) using data available on a trust wide electronic system. Each directorate produced patient tracking lists from the electronic system and shared this with clinical staff to promote discussions around managing patient’s timely access to treatment and identifying any capacity gaps.

There were weekly access meetings to monitor performance. These were attended by the chief operating office and deputy operating officer, the RTT performance manager and RTT cancer manager, there was also a quality and safety representative. At these meetings, the RTT position was discussed as well as any remedial action plans required for specialties that were not performing against the national standard. The divisions also attended a weekly meeting where the PTL, clinic utilisation and escalation of potential breaches were discussed.

Improvement plans were in place that clearly defined the process for both the 2 week waits and the 18 week pathway. At the time of our inspection, there were no delays in entering the referral onto the system, referrals were vetted and triaged by the specialty consultant and appointments were then booked according to priority.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

Non-admitted pathways are the waiting times for patients whose treatment started during the month and did not involve admission to hospital. Although data on non-admitted pathways is still collected, there is no longer an operational waiting time standard.

From October 2018 to April 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways was generally similar to the England overall performance. The latest figures for April 2019, showed 86.7% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

The trust did not submit any RTT data to NHS England from September 2017 to September 2018.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, East and North Hertfordshire NHS Trust.**
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Seven specialties were above the England average for non-admitted pathways 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>99.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>97.1%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>93.4%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.6%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.8%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>88.5%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>87.9%</td>
<td>83.7%</td>
</tr>
</tbody>
</table>

Nine specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>90.6%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Other</td>
<td>85.2%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.5%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>81.7%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>81.6%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>74.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>69.2%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>68.0%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>67.3%</td>
<td>81.2%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From October 2018 to April 2019 the trust’s referral to treatment time (RTT) for incomplete pathways was better than the England overall performance. The latest figures for April 2019, showed 88.1% of this group of patients were treated within 18 weeks versus the England average of 86.1%. Incomplete pathways, often referred to as waiting list times, are the waiting times for patients waiting to start treatment, as at the end of each month. The incomplete waiting time operational standard was introduced in 2012 and states that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways.

From October 2018 to June 2019, the trust reported 104 patients waited longer than 52 weeks from referral to treatment. In August 2019 there were 35 patients waiting over 52 weeks from referral to treatment. In Gastroenterology, there was one patient who had waited over 52 weeks and had not received their first new appointment. Each division completed harm reviews for patients who had waited over 52 weeks, which were recorded as an incident and reviewed by the medical director. Data provided by the trust showed there were no incidents where a harm review indicated moderate or greater harm. The trust had a policy for clinical harm reviews.

The trust did not submit any RTT data to NHS England from September 2017 to September 2018.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, East and North Hertfordshire NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Twelve specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>100.0%</td>
<td>82.1%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.1%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>
Plastic surgery  97.6%  82.4%
Geriatric medicine  96.7%  95.8%
Urology  96.3%  85.1%
Ophthalmology  95.0%  86.7%
Neurology  94.8%  86.6%
Ear, nose & throat (ENT)  92.2%  83.9%
General surgery  92.1%  83.8%
Oral surgery  87.2%  82.3%
Cardiothoracic surgery  85.7%  84.1%
Trauma & orthopaedics  84.5%  81.3%

Six specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping | Result | England average
--- | --- | ---
Thoracic medicine | 88.3% | 88.9%
Cardiology | 87.8% | 89.4%
Gastroenterology | 87.1% | 88.2%
Rheumatology | 84.5% | 91.3%
Dermatology | 83.5% | 89.6%
Other | 83.3% | 89.1%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust’s performance has been above the national standard and the England average performance from July 2018 to March 2019. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), East and North Hertfordshire NHS Trust

(Source: NHS England – Cancer Waits)
Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust failed to meet the 96% operational standard and performed worse than the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all periods from April 2018 to March 2019. The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), East and North Hertfordshire NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust failed to meet the 85% operational standard and performed worse than the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, East and North Hertfordshire NHS Trust

(Source: NHS England – Cancer Waits)

Managers worked to keep the number of cancelled appointments to a minimum. The trust had implemented a text reminder messaging service which prompted patients of their next appointment date. Staff told us the system had improved the number of patients who cancelled
their appointments at short notice and had also reduced the number of patients who ‘did not attend’ (DNA).

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff told us the cancellation of whole clinics was not a frequent occurrence, and that the bookings team were very good at bringing patients back in to clinic within a short period of time. Data provided by the trust following our inspection showed there were 107 cancelled clinics between May and July 2019 with a total of 1239 appointment slots which required rebooking. Of the 107 cancelled clinics, 15 were cancelled less than a week prior to the clinic date, and four were cancelled on the day. Sickness and staff availability were the main reasons why clinics were cancelled at short notice. If clinics were cancelled with less than three weeks’ notice, patients were contacted by phone. If there was more than three weeks’ notice, then patient would receive a letter informing them of their new appointment date.

Staff supported patients when they were referred or transferred between services. Patients who became unwell in the department were support and transferred to appropriate services at the Lister Hospital and admitted as inpatients if required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, the time taken to respond to complaints was not always in line with the trust target.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns, and the service clearly displayed information about how to raise a concern in patient areas. We saw information leaflets and posters through the department informing patients how to make complaints, and those we spoke to said they would raise their concerns with the nursing staff or their doctor during their appointment.

Staff understood the policy on complaints and knew how to handle them. Staff were advised to direct patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly. There was no patient advice and liaison service (PALS) office at the Queen Elizabeth II Hospital, however patients were directed to use the service and raise a complaint with the PALS office at the Lister Hospital.

Trust level

From April 2018 to March 2019, the trust received 333 complaints in relation to outpatients across the whole trust (34.4% of total complaints received by the trust). Of the 333 complaints, 59 complaints were specific to outpatients at QEII and 56% of those complaints had been responded to within the agreed timeframe. The trust took an average of 51.1 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed within 5 working days. We raised our concerns with the outpatient sister regarding the time to respond to complaints, who told us that the outpatient department at the hospital did not receive a large number of complaints, and their turnaround time was shorter than the average of 51 days.
Managers investigated complaints and identified themes. Senior staff described their approach to complaints and said they tried to meet all complainants on the day while they were still in the hospital, to try to understand their complaint and resolve as much as possible, before proceeding with a formal complaints process. Staff asked the complainant whether they would prefer a written or verbal response. Following completion of the investigation, they would offer a face-to-face meeting with the complainant to explain and apologise. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of learning from complaints was discussed staff meetings and included in newsletters.

A breakdown of complaints by type is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>119</td>
<td>35.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>106</td>
<td>31.8%</td>
</tr>
<tr>
<td>Patient Care</td>
<td>68</td>
<td>20.4%</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>35</td>
<td>10.5%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>333</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Due to the format of the data received we were unable to breakdown complaints by site level.

During our inspection, senior staff across the outpatient department including breast clinic, ear nose and throat (ENT) and ophthalmology told us that complaints were usually about waiting times.

**Number of compliments made to the trust**

From April 2018 to March 2019, there were three compliments about outpatients at the trust (6.4% of the total compliments received across the trust). Two of the compliments were received by Audiology at Lister Hospital and one compliment was received by the breast clinic at the QEII Hospital.

The trust stated that compliments are received through the CEO’s office, these were responded and sent to the relevant areas by the CEO. They are then shared with the complaints team for recording.

The trust also stated that they received multiple compliments via their social media platforms and also direct compliments to areas across the trust. The trust was currently developing a consistent approach on how to capture, record and share themes and trends that relate to compliments and praise for services.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. Local leaders understood and managed the priorities and issues the service faced and they were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, there was limited visibility and engagement of senior leaders.

The outpatients’ service at the Queen Elizabeth II Hospital was part of the clinical support services (CSS) division, apart from ophthalmology, which was part of the surgery division, and the children’s outpatient department which was part of the women’s and children’s division. There was a clear management structure in place with lines of accountability. The CSS division was led by a divisional chair, divisional director and divisional head of nursing, who formed a triumvirate, which managed the division. The triumvirate had all completed a range of specialist leadership training and came from clinical backgrounds. A general manager supported the division.

An experienced sister and a senior staff nurse managed the outpatients’ service. The team appeared focused and driven and staff reported leadership within the outpatient department was strong, with visible, supportive, and approachable managers. However, while staff were aware of immediate managers within department, staff could not recall the names of the divisional team. Divisional leaders managed a number of services within the CSS division including outpatients, diagnostic imaging, health records, and pharmacy, and their time was split between them. Senior staff told us divisional leaders completed a formal visit to the department at several times a year. Staff within the outpatient department told us they had not seen any divisional managers in the department in recent months. Staff were aware of the senior management team and could recall the name of the chief operating officer and chief executive. Staff told us that there was regular communication from the executive team on the intranet and via emails.

The trust provided development programmes for staff, which supported them to develop leadership and management skills. Senior staff told us the trust was supporting external leadership courses.

However, staff across the breast service felt disengaged from the senior management team at a divisional level and did not feel supported. Staff told us members of the management team had not visited the department in several months, change was generally slow and staff felt managers did not understand the service. Staff at all levels within the team including consultants, nurses and administration staff, had raised concerns around clinic capacity and overbookings, limited quiet private spaces for patients, and the need for a breast unit manager, however they had received limited responses. Staff across the service felt that at a divisional level they were focusing on seeing and treating the greatest number of patients, with a limited focus on patient experience.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However, the service’s vision had not been developed with all relevant stakeholders. Staff were unaware of the local vision for the outpatients service.
The trust had a quality strategy for 2019 to 2024 aligned to the trust values, and staff were aware of the trust values. There was information about the trust strategy displayed within the outpatient department, and staff we spoke to were aware of the vision and strategy at a trust level. There was high awareness of the trust’s PIVOT values for putting patients first, striving for excellence and continuous improvement, valuing everybody, being open and honest and working as a team.

The outpatient service at the Queen Elizabeth II Hospital did not have a specific strategy. However, the service had a local plan aligned to the overarching trust strategy. Senior staff told us the vision of the service was to continuously improve the quality of the services in order to provide the best care and optimise health outcomes, for each and every individual that accessed the services. Staff we spoke with were not aware of the service’s vision and had not been involved in its development.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke to including nurses, clinicians, qualified allied health professionals felt supported by their colleagues and their immediate managers in their departments. They told us they were proud to work within the trust. It was evident that staff were passionate about the services they provided. Staff were committed to providing the best possible care for patients. Staff said their line managers looked after them well. We saw positive and supportive interactions between all staff. Clinical leads within the department described having an open-door policy where any member of staff could see them privately.

This was confirmed by staff we spoke with who felt they could address any concerns with the clinical leads and their line managers. There was a culture of collective responsibility between teams. Openness and honesty were encouraged at all levels and staff said they felt able to discuss and escalate concerns with their immediate line manager and clinical leads without fear of reprisal. However, most staff did not understand and did not know who the trust’s freedom to speak up guardian was. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.

The outpatients’ service celebrated staff success. Compliments received were shared with staff at team meetings and on notice boards. The outpatient sister had been nominated and won the clinical support services (CSS) division employee of the month award for outstanding work in outpatients nursing, and was featured in the CSS newsletter.

We saw that there were various methods of communication across the team, including a newsletter, whiteboards and notice boards. Some staff said they could access the executive team to escalate concerns and there was effective communication from the chief executive officer.

However, morale within the breast service was variable. While most staff said that morale was good, and they were happy with their work, most also said they felt the volume of work was overwhelming at times, felt pressured and were concerned about patient experience due to the volume of patients they were seeing. Some staff felt demoralised by the limited or complete lack of improvement made to address their concerns by staff at a senior level, specifically around overbooking of clinics, lack of a private quiet space and the need for more staff. While staff felt supported with their concerns by their immediate line managers and clinical leads, they felt there
was limited support for the department from senior and divisional leadership.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The outpatient service had governance systems that ensured there were structures and processes of accountability in most areas to support the delivery of good quality services. The outpatient sister reported directly to the senior leadership team with clear lines of escalation in place. All staff from the outpatient service attended meetings through which governance issues were addressed. The meetings included team meetings, and monthly governance meetings. There was a standard agenda which covered topics such as incidents, risks, training compliance, staffing, mortality, audits, guidance, complaints and performance. The monthly divisional board meetings fed into the accountability review meetings with the executive team. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was mostly provided to staff during team meetings.

The outpatient department had regular team meetings for nursing staff and were held every two weeks which were chaired by the senior staff nurse for outpatients. They did not have a set agenda, however often covered topics including complaints, training compliance, and incidents. Reception staff said they had team meetings three to four times a year. The oral surgery and orthodontics team had monthly team meeting on audit days. When staff were unable to attend, steps were taken to communicate key messages to them which included e-mails and minutes of the meetings being available on the staff notice board.

Governance processes were effective to ensure all outpatient staff received an appraisal.

Clinical staff members were clear on their objectives and understood how they contributed to the services success. The outpatient sister identified training needs of staff through appraisal and supported completion of specialist training to support patient care.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had arrangements in place for identifying, recording and managing risks, and maintained a divisional risk register which was reviewed at monthly governance meetings. However, the outpatient department did not have a localised risk register. This was being looked at by the senior management team. Their risks were part of the clinical services division risk register.

We saw that all risks were reviewed regularly and updated when any actions were taken to mitigate risk or harm. Each risk had a review date and a nominated manager who was responsible for tracking the risk identified. We saw evidence that reviews had been undertaken, what mitigation actions had been completed, and if the risk had reduced/increased. The main
risks in relation to the outpatient service were long delays for outpatients waiting for ambulance transport. We noted a nursing rota had been implemented to ensure staff always remained with patients while they waited, and staff nurses had been given guidance on the process for patients waiting for transport.

Performance review meetings were held for outpatient services monthly. A performance dashboard was produced to monitor the number of outpatient attendances, cancellations and patients who did not attend their appointment. We were told the leaders for outpatient services discussed successes and challenges at the meeting and provided feedback to staff at team meetings.

The division presented a quarterly performance report for the trust finance and performance committee. This provided a summary of quality (incidents, risks, complaints and audits) performance, cancer targets with a recovery trajectory, finance, and workforce measures. It also identified key challenges and progress against the cancer strategy.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The outpatient department had a wide range of information available to enable managers to assess and understand performance across the division. The trust produced performance dashboards monthly, which listed performance against a series of indicators. The performance indicators covered a range of themes which included number of patients who ‘did not attend’ (DNA), the number of unused appointment slots, the trust cancellation rate and the discharge rate. The outpatient department had clear performance measures, which were reported and monitored. These included, key performance indicators, referral to treatment times, treatment to reporting times, and friends and family test results. The data from these was used to drive forward changes in practice.

Staff were able to access patient electronic records appropriate to the needs of the investigation being completed. The outpatient service used both paper and electronic records. Patient demographic details (such as name, date of birth and address) and referrals, were stored electronically. Results of diagnostic and blood tests were also available electronically which all relevant staff could access. Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Electronic patient records were kept secure to prevent unauthorised access to data, and authorised staff demonstrated they could be easily accessed when required. Staff across the outpatient department were aware of the requirements of managing a patient’s personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within the regulations.

During the inspection we saw appropriate use of computers with no screens detailing patient information left unattended. There were sufficient computers available to enable staff to access the system when they needed to. Computers were available in all the areas we visited. All staff had secure, personal login details and had access to email and all hospital information technology systems. Data provided by the trust following our inspection showed that staff were above the trust target of 95.0% compliance for information governance with 100.0% compliance.
for nursing staff.

Staff confirmed they received information in a variety of methods, which included; team meetings, notice boards and newsletters.

Policies were stored on the trust’s intranet and were easily accessible. Staff we spoke to could locate and access relevant polices and key records easily. All staff had access to the trust’s intranet to gain information on policies and national guidance, and to access online e-learning training.

Electronic systems were used to monitor quality of care. There was a risk management system where incidents and complaints were recorded. There were also systems in place to ensure that data and notifications were submitted to external bodies as required.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The outpatients’ department sought feedback from the relatives and carers of patients who had attended the department which were acted on to shape and improve services. The trust participated in the NHS Friends and Family Test (FFT), which allows patients to express their opinions, with the aim of staff acting upon them leading to increased patient satisfaction. In March 2019, 669 patients responded to the FFT (*Source: DR185*). Of these, 74% of patients said they would be ‘extremely likely’, and a further 22% ‘likely’ to recommend the outpatient service. The remaining were ‘neither likely or unlikely (1.5%), ‘unlikely’(0.6%) or ‘extremely unlikely’(1%) to recommend the service. We saw FFT comment cards were available in all outpatient waiting areas, and there were posters displayed which encouraged patients to leave feedback. Following their appointment, staff handed patients comment cards and ask them to complete them on their way out. Staff told us that patient feedback was discussed and shared through verbal huddles. The results were also reported at the outpatient team meetings.

There were posters displayed in the main areas of the department, showing, “you said,” “we did” information. For example, in the breast clinic we saw patients had raised waiting times in clinic as an issue. Following this feedback, the hospital implemented a notice board which displayed how long a delay there was in appointment times. Staff also verbally announced the wait time periodically to patients in the waiting areas.

The outpatient sister told us the service participated in International Women's Day, which included a 'mini health check-up' for all women attending the hospital. Patients were offered and encouraged to undergo a cervical screening or mammogram, without the need to pre-book an appointment. Staff said the event was well attended and had plans to hold the event again next year.

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.

Staff told us that local and departmental managers were approachable and that they felt comfortable to raise any concerns with them. Information was shared with staff in a variety of ways, such as face-to-face, email, staff newsletters, monthly trust communications, and noticeboards.
Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them, however action plans were not always comprehensive or fully completed. Leaders encouraged innovation.

The clinical leads within the outpatient service took action to make improvements in the running of services. They had regular meetings where learning was discussed in a variety of forums. For example, team meetings and quality and governance meetings.

The trust provided us with a copy of the outpatient action plan. This included actions related to infection prevention and control, equipment and mandatory training. However, we noted this was not comprehensive, did not identify target dates for completion or include dates when issues had been identified and added to the plan.

During our last inspection, we found the ocular computed tomography (OCT) machine in the ophthalmology department was eight years old and had not been regularly serviced. The OCT machine recorded images across the eye. The trust confirmed that the machine was no longer supported for software updates or servicing by the manufacturer. We were therefore unable to confirm that the machine had recently been suitably serviced or calibrated. During this inspection, we found the OCT machine had recently been replaced and staff told us it was a noticeable improvement compared to the previous model. They said it was very quick at processing test results, and the consultants frequently requested to use it for their patients.

The trust responded to our concerns raised during inspection and actions were taken. For example, we saw checks were not always performed on portable oxygen cylinders and suction machines. During our inspection, we raised our concerns with the outpatient sister who took immediate action. All staff across outpatients were reminded verbally to ensure checks were completed, and a reminder was recorded in communication books for staff not on shift.