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

James Paget University Hospital provides care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The trust’s main site in Gorleston is supported by the Newberry Clinic and other outreach clinics in the local area.

James Paget Hospital officially opened in July 1982. It was established as a third wave NHS trust in April 1993 and became a Foundation Trust in August 2006.

The trust provides a full range of general acute services plus a number of specialised services; including a hyperbaric chamber for ventilating and monitoring critically ill patients whilst they are receiving hyperbaric oxygen therapy. The trust works collaboratively with local primary care colleagues, community services and other acute trusts, to ensure that patients receive the best care in the right place.

The trust has around 500 inpatient beds located in James Paget University Hospital. These are a mix of critical, intensive and high dependency care, general surgery and medicine, maternity, paediatrics and neonatal, and escalation beds used when the trust is experiencing high demand and needs to deal with an increased number of patients needing care.

The trust employs over 3,000 staff, both part and full time, making them the largest local employer in the area. As a university hospital, the trust also trains over one third of the medical students from the University of East Anglia.

(Source: Trust website)
Acute sites at the trust

A list of the acute sites at James Paget University Hospitals NHS Foundation Trust is below.

<table>
<thead>
<tr>
<th>Name of site</th>
<th>Address</th>
<th>Services provided</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Paget University</td>
<td>Lowestoft Road, Gorleston, Great Yarmouth,</td>
<td>General acute services plus a number of specialised</td>
<td>Great Yarmouth, Lowestoft and Waveney</td>
</tr>
<tr>
<td>Hospital</td>
<td>NR31 6LA</td>
<td>services, including a hyperbaric chamber</td>
<td></td>
</tr>
<tr>
<td>Newberry clinic</td>
<td>Lowestoft Road, Gorleston, Great Yarmouth,</td>
<td>Community paediatric clinics</td>
<td>Great Yarmouth, Lowestoft and Waveney</td>
</tr>
<tr>
<td></td>
<td>NR31 6SQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norfolk Coastal Centre</td>
<td>Norfolk Coastal Centre, Wood Farm Lane,</td>
<td>Medical outpatient service</td>
<td>Great Yarmouth, Lowestoft and Waveney</td>
</tr>
<tr>
<td></td>
<td>Beacon Park, Gorleston, NR31 9AQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beccles Hospital</td>
<td>St Marys Road Beccles, Suffolk, NR34 9NQ</td>
<td>Ophthalmology service</td>
<td>Great Yarmouth, Lowestoft and Waveney</td>
</tr>
</tbody>
</table>

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

As part of the well-led inspection process, we interviewed the executive and non-executive directors of the board and a range of senior staff across the organisation. We looked at performance and quality reports, minutes of meetings, personnel files, audits and action plans. We reviewed previous board meeting minutes and papers to the board.

We looked at personal files of the executive team, incidents, complaints and sought feedback from a wide range of staff and asked their views on the leadership and governance of the provider.

Is this organisation well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. The trust board had the appropriate range of skills, knowledge and experience to perform its role.

The trust had a cohesive, experienced board and leadership team. The trust board had a range of experience at executive level which enabled them to function effectively. The skills, ability and commitment of the board members allowed them to provide sustainable care and development opportunities.

We spoke with all the board members and found them to be cohesive, with shared visions of continually improving care for patients and promoting the wellbeing of their workforce. It was overwhelmingly evident that the board were all proud of the staff working within the organisation. To support this, the trust had a five year people strategy which recognised that staff were the trust’s greatest asset and the executive team’s ambition was to be the local employer of choice, with a compassionate, supportive culture.
There was a council of governors which included public and staff appointed governors. The role of the governors was to hold the non-executive directors to account for the performance of the board and contribute to the development and provision of services within the hospital. Our interviews with governors and senior leaders demonstrated that there was a collaborative working relationship between governors, non-executive directors and executives. The trust provided development days for governors and those we spoke with told us they were useful.

We reviewed five personal files of executives to determine if employment checks had been performed in accordance with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This process ensured that directors are fit and proper to carry out their role. We observed that FPPR checks were in place. The employment process also included enhanced Disclosure and Barring Service (DBS) checks, insolvency and bankruptcy checks, disqualified director register checks and occupational health checks of directors appointed to the board. Further checks included annual self-declarations for further assurance.

Since our last inspection the trust had appointed a new chief executive officer (CEO) who had been in post since August 2019, and had previously been the interim CEO since December 2018. There had been a new appointment to the chief operating officer role and the head of human resources. Throughout our inspection, despite the changes of staff, executives, non-executives and governors described strong leadership and respectful close working relationships within the executive team.

Both the executive directors and non-executive directors (NEDs), had the relevant operational and financial experience, and knowledge. For example, the chief finance officer and the NED chair of the performance and finance committee could clearly describe the trust’s financial position. The board had agreed a number of financial incentives to improve income, for example, increasing private patient activities, commissioning out training to other providers and upgrade staff residencies to increase rental contracts.

We spoke with two governors who told us that they had good working relationships with the NEDs and the executive team were very accessible. They told us they were able to constructively challenge the NEDs, chair or the directors if they needed to. The governors were very active and met regularly for updates from the NEDs, they engaged with staff within the hospital and worked hard to engage and communicate initiatives with the public within the hospital and the community.

During our core service inspection, all staff we spoke with told us that the CEO was visible and had an open door policy. Senior leaders and staff worked together to deliver a shared vision and used their individual strengths to improve services. Non-executive directors and governors undertook regular visits to wards and operational areas and were also involved in undertaking quality visits as part of the trust’s internal audit and compliance processes.

The executive team had received a 360-degree review a year prior to our inspection, (colleagues provided feedback about the individual executives and the team also self-evaluated themselves). All of the executives had a coach and attended away days which promoted teamwork.

The trust had an operational structure which had two divisions, the divisions were encouraged and supported by the executive team to take responsibility and own their business. A triumvirate team,
consisting of a divisional director, an associate director of operations and a divisional head of nursing/midwifery led each division. The triumvirate team for each division were supported at a local level by clinical directors, operational managers and matrons.

Throughout our well led inspection we found the members of the trust board worked as a team to function in unity to create a culture where, high quality patient centred care could be delivered and maintained.

**Board Members**

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 57.1% were female.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>53.8%</td>
</tr>
</tbody>
</table>

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

Of the executive and non-executive board members non were BME which was reflective of the local population. There was a good representation of male and female members within the board.

**Vision and strategy**

The board and senior leadership team had set a clear strategy, vision and values that were at the heart of all the work within the trust. They worked hard to make sure staff at all levels understood them in relation to their daily roles.

The strategy, vision and values of the trust was promoted throughout the core services we inspected and visible for staff to see. All decisions and performance initiatives were linked to the strategy and underpinned the board assurance framework (BAF), this is a key mechanism which the board used to reinforce strategic focus and improve management of risk. The trust company secretary had recently redesigned the BAF, maintained it and made timely amendments when needed.

Staff were given a handbook when they started working in the trust which included the trust’s values and behaviours. The directors, non-executive directors and governors all told us the trust’s values underpinned the work that they did, and they also had behaviours they expected staff to display which were:

- Courtesy and respect
- Attentively kind and helpful
- Responsive communication
- Effective and professional
We reviewed board agendas, board meeting minutes, board papers and a range of documents including the board assurance framework. All of which referenced the strategic objectives which meant these were reflected during board meetings.

The corporate induction programme included the trust’s vision and values. The trust’s values were displayed throughout the hospital to inform patients and members of the public of the trust’s values. All board members displayed a knowledge of the vision and values. The board was open and transparent with patients and their staff. Every member of the executive team said they were proud of their staff and demonstrated a passion to improve services for the patients’ they served.

The leadership team was working with the wider local health economies to improve services for patients that were sustainable and accessible across Norfolk, Lowestoft and Waveney. The trust was extremely supportive and proud of their involvement with the regional service transformation programme (STP). All the directors we spoke with had a shared vision to integrate services for seamless care and improved outcomes for patients. The CEO told us that their trust was an active voice within the STP meetings.

We reviewed board minutes from March and April 2019, which showed detailed minutes were taken and it was apparent that non executives were confident to make appropriate challenges, for example, non executives asked for clarity and assurances on a number of occasions.

The trust board was planning ahead and recognised the importance of improving sustainable care for the public. They had recruited a director of transformation and workforce who worked with external agencies to deliver projects to improve care, for example, one of their main projects was to improve efficiency within the outpatient’s department to become a outpatients village with a one stop model by 2020.

The trust had a pharmacy and medicines optimisation strategy, which was monitored by the chief pharmacist and aligned with the trust’s vision and strategy. The executive team had made a significant investment in response to risks identified in a report submitted to them and recruited an additional 10 pharmacists to support the ward areas.

**Culture**

There was a culture of high quality, sustainable care. Staff felt supported, respected and valued.

Staff throughout the trust had told us during our core service inspection there was a positive culture where they felt valued by senior staff. All staff we spoke with said they were able to raise concerns and report incidents, without reprisal and there was a non-blame culture.

The executive team demonstrated a shared vision and encouraged and motivated staff to improve and succeed. The trust had a director of strategy and integration recruited to improve relations with internal and external stakeholders to facilitate improvement projects.

Board members, governors and senior leaders made sure they visited all of their services provided and fed back to the board to discuss challenges staff and the services faced. Staff told us they
were supported by all levels of management and given the opportunities to put forward ideas to shape services provided by the trust.

The workforce strategy included new approaches to grow your own workforce with apprenticeship schemes and talent mapping that had provided opportunities for identifying future leaders from within the organisation. We were provided with an example where this had occurred. One member of staff had progressed from a domestic role, to a board director.

Freedom to speak-up guardians (FTSUG) were introduced following Sir Robert Francis’s ‘Freedom to Speak-up Review’ (2015). Their role is to work with leadership teams to create a culture where people can speak-up to protect patient safety. The executive team recognised the importance for staff to have a voice and be able to speak up and recruited six FTSUGs. However, during our core service inspection we did not see this was promoted throughout the hospital and many staff were not aware of who the FTSUG’s were. The trust had a FTSUG policy in line with national guidance, in November 2018, a staff survey was launched to obtain staff opinion to make improvements to the role and an action plan to achieve improvements, which was monitored by the director of governance.

The FTSUG we spoke with told us that there were now four FTSUG’s and the team had received six contacts from August 2019 to September 2019, they explained that the low numbers were due to the trust having good managers and an open culture. The CEO had an open door policy and staff were happy to contact the CEO directly. The executive team recognised that the role needed further development and had recently recruited a lead to take the FTSUG team forward.

Appraisals were in place for providing executives with high quality annual reviews which included career development conversations and setting objectives for the next year. All senior leaders told us that they had received a meaningful appraisal.

The trust had supported services to change to electronic job planning, this meant that consultants were on-call for a week in their speciality. The consultant on-call was assisted by the consultant on-call from the previous week who managed theatre cases. This new on call system also improved continuity of care to patients. Consultants we spoke with told us this system worked well and it enabled them to provide greater support to junior doctors.

**Staff Diversity**

The trust provided the following breakdowns of medical and dental staff and qualified nursing midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A White - British</td>
<td>34.6%</td>
<td>69.4%</td>
</tr>
<tr>
<td>B White - Irish</td>
<td>2.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>C White - Any other White background</td>
<td>10.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td>C3 White unspecified</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CA White English</td>
<td>0.5%</td>
<td>2.8%</td>
</tr>
<tr>
<td>CB White Scottish</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>CF White Greek</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>CK White Italian</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
The trust had an equality and diversity policy, and ensured that all services submitted equality and diversity data, which was monitored by the workforce directorate and then to the board for oversight and discussion.

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 score for the following theme was significantly higher (better) when compared to the 2017 survey:
- Equality, diversity and inclusion

The trust’s 2018 score for the following theme was significantly lower (worse) when compared to the 2017 survey:
- Health and wellbeing

(Source: NHS Staff Survey 2018)

The trust had actions in place to improve this measure, they commenced a tea and empathy event. Schwartz rounds were commenced to keep staff well at work, these are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim was to offer staff a safe environment in which to share their stories and offer support to one another. The trust had placed the concerns about staff wellbeing on the board assurance framework.

**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:
- These scores are un-weighted, or not adjusted.
- 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.
- 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.
- 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.

### WRES Indicators from ESR (HR data)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>0.0%</td>
<td>3.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>6.6%</td>
<td>6.1%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>2. Proportions of shortlisted staff being appointed to positions</td>
<td>35.6%</td>
<td>36.2%</td>
<td>-27.6%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>0.9%</td>
<td>0.7%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>53.7%</td>
<td>52.6%</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

### WRES Indicators from the NHS staff survey

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there significant differences between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust</td>
<td>BME and white staff?</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust</td>
<td>BME and white staff?</td>
</tr>
</tbody>
</table>

### Trust staffing numbers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>[BME: Voting Board Members] and Board compared to overall staff demographic</td>
<td>[0]</td>
<td>[1]</td>
</tr>
</tbody>
</table>

**Key**
- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ● Statistical analysis not undertaken as less than 30 BME staff responded
- ● Statistically significant improvement
- ● No statistically significant change
- ● Statistically significant deterioration

As of March 2018, none of the ESR staffing indicators shown above where statistical testing
was undertaken (indicators 1a, 2 and 3) showed a statistically significant difference in score between white and BME staff. Statistical analysis was not undertaken for indicator 1b as fewer than 30 BME staff responded.

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

8. 16.7% 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 6.2% of White staff. The score had decreased by 0.6% when compared to the previous year, 2017, although this was not a significant change.

There were no BME voting board members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

We reviewed the annual WRES report 2018 to 2019 to the workforce, education and wellbeing steering group. Data was submitted on behalf of the trust in August 2018 in line with national reporting requirements.

**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 95.9% and 98.0% from June 2017 to May 2019.

The data appeared to be stable with only random variation over the whole period.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from April 2018 to March 2019 were higher than the England average in every month with the exception of March 2019 when the rate was slightly lower.
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed worse than expected for two indicators (clinical supervision and educational supervision) and the same as expected for the remaining 16 indicators.

![Graph showing performance over time](Source: NHS Digital)

### Survey area

<table>
<thead>
<tr>
<th>Curriculum coverage</th>
<th>Educational governance</th>
<th>Reporting systems</th>
<th>Rota design</th>
<th>Teamwork</th>
<th>Overall satisfaction</th>
<th>Clinical supervision</th>
<th>Clinical supervision out of hours</th>
<th>Handover</th>
<th>Induction</th>
<th>Adequate experience</th>
<th>Supportive environment</th>
<th>Work load</th>
<th>Educational supervision</th>
<th>Feedback</th>
<th>Local teaching</th>
<th>Regional teaching</th>
<th>Study leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

(Source: General Medical Council National Training Scheme Survey)
The trust had a ‘Guardian of Safe Working Hours’ for junior doctors. The guardian’s role was to ensure that providers identify and respond to issues around safe medical staffing, to deliver quality care and keep patients and staff safe from avoidable harm. Safeguards around working hours of doctors in training (junior doctors) had been designed to ensure that the risk was effectively mitigated and that this mitigation was assured. The trust guardian reported to the medical director, reviewed themes and trends from feedback from junior doctors, and produced annual reports to the board.

The trust had a duty of candour policy, duty of candour (DoC) is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014 which states, ‘As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology’. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. We looked at examples of how the organisation applied duty of candour, the responsibilities of staff at all levels were detailed, and open and honest throughout the organisation.

Staff told us throughout our core service inspection there was a no blame culture and how they were actively encouraged to raise concerns and report incidents without fear of retribution. Managers encouraged staff to be open and honest in relation to issues arising and to challenge poor practice. We found in all cases we reviewed that families and carers had been contacted explanations and an apology were given. The patient and or families were invited to be part of the investigation process.

The staff side had a good relationship with the executive team and met every other month with the chief executive officer, director of HR and service managers.

**Governance**

The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the service and they responded when services needed more support.

There were effective structures and systems in place to monitor governance and accountability throughout the organisation to support the delivery of the strategy. There were board assurance sub-committees which reported into the board, these were: the audit committee, finance and performance committee, executive nomination and remuneration committee, safety and quality committee, and the workforce, education and research committee. Board assurance committees gave assurances to the board on performance, operation and financial status of the trust. All committees had terms of reference, agendas and minutes.

Papers and reports for board meetings and other committees were of a good standard and contained appropriate information. We saw from reviewing board meeting minutes that there was evidence of challenge (including from NEDs) and discussion on reports being presented. The trust had a safety and quality governance committee, which reviewed the exception reports, for the top risks from divisions, escalation from performance reviews, clinical effectiveness, patient experience and patient safety. The panel that reviewed serious incidents reported directly to the safety and quality governance committee which reported directly to the board.
Board Assurance Framework

The trust provided their board assurance framework (BAF), which detailed four strategic objectives and the accompanying risks within each as of May 2019. Listed below:

1. Deliver the best possible level of safe and effective care.
2. Provide education, support and development for the trust’s staff to deliver excellence in practice and be the employer of choice.
3. Effectively manage the trust’s financial resources, estate and infrastructure to ensure it is sustainable.
4. Actively participate in innovation, research and partnerships to transform the trust’s services.

(Source: Trust Board Assurance Framework – May 2019)

The BAF provided the board of directors with an assurance that risks to achieving the trust objectives were appropriately mitigated. The executive team told us that the BAF mapped the trust’s highest and extreme risks, and ensured controls were in place to mitigate risks whilst actions were being implemented. It was also cross referenced with the clinical audit plan and risk register.

We reviewed the BAF at the time of our inspection, the four strategic ambitions were clear, and risks were aligned to each ambition within the BAF. All risks were rated, with a named executive lead, there were control measures, actions and each risk had a timescale to be achieved. There was evidence of BAF reviews at the following meetings; at the workforce, education and research committee meetings.

Management of risk, issues and performance

The executive directors were aware of the risks within the organisation and ensured learning from incidents, complaints and safeguarding alerts was shared to drive forward improvements.

There was an effective framework and systems in place to monitor quality of care and performance within the trust. The board and executive level groups received risk based exception reports which had been benchmarked against national targets and local priorities. This meant that any areas of non-compliance would be highlighted to the executive team to enable actions to be identified and implemented.

The trust had a policy for the management of incidents and serious incidents. We observed embedded systems within the trust to identify learning from incidents and complaints, throughout our core service and well led inspection.

We reviewed a selection of patient safety incidents and observed they were managed correctly. They were graded appropriately, and each incident had been investigated and an action and learning documented.
The executive team told us financial outcomes had improved over last year due to the delivery of the trust's cost improvement programme (CIP) plan. Financial governance and oversight was resilient and the trust's financial and operational performance was in a positive balance. The finance and performance committee was responsible for monitoring finance and reported monthly into the board meetings to update the executive team on financial performance and status.

Finance was discussed at divisional governance meetings, divisions discussed their financial plans and delivery of their CIPs. The executive team told us that each CIP was subject to a quality assessment and would not be agreed if it compromised the quality of patient care.

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£191.9m</td>
<td>£189.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£2.6m</td>
<td>(£7.3m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£189.3m</td>
<td>£197.0m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£187.0m</td>
<td>£191.7m</td>
</tr>
</tbody>
</table>

The deficit reported in 2018/19 was lower than the previous year, 2017/18. Projections for 2019/20 indicated that there would be a surplus of £1.7m.

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

The trust regularly engaged with NHS Improvement, regarding their financial plans. NHS Improvement perform a use of resources (UOR) assessment of all acute trusts to review how they utilise their resources to promote high quality care and treatment for patients. This report is published at the same time as the inspection report.

### Trust corporate risk register

The trust had a risk management strategy 2021 which provided staff with the framework and processes to identify, mitigate and manage risk within the trust. The executive team had sight and awareness of the most significant risks which were recorded on their corporate risk register. The risk management strategy also detailed the board of directors’ responsibilities which we observed had been achieved, for example an annual review of the strategic objectives.

The risk register we reviewed was detailed, with the owner of the risk identified and all risks had been reviewed and were in date. The risk register was monitored and reviewed by the executive team at board meetings.

The trust provided a document detailing their 10 highest profile risks, as of June 2019. Each of these has a current risk rating of eight to 12 (out of 25) and were classified as high (orange).
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Next review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/01</td>
<td>The European Falsified Medicines Directive (FMD) becomes UK law on the 9th February 2019. This will require all pharmacies to scan each pack of a medicine as it leaves the pharmacy to delete it from the European database of medicines packs ('SecurMed'). Currently, the pharmacy stock control system (JAC) and infrastructure (scanners etc.) is not in place to enable the trust to meet their legal obligation to do this.</td>
<td>12</td>
<td>Moderate</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>2018/02</td>
<td>Reduction in funding for research &amp; development due to decreased income from research networks and commercial partners will require downsizing the department and so reduce ability to service research projects throughout the trust, both new and existing. Possibility that existing studies will need to close with detrimental effect on patients; impact on recruitment and retention and trust reputation.</td>
<td>10</td>
<td>Moderate</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>2018/46</td>
<td>Slips, trips and falls – external pathways and roadways due to poor condition of road and pavement surfaces (site wide).</td>
<td>9</td>
<td>Moderate</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>2013/23</td>
<td>Passwords not renewed, are shared and are not complex. Loss of patient data, inappropriate access to patient data, data sharing. Reputational damage. Financial penalties.</td>
<td>8</td>
<td>Low</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>2017/09</td>
<td>Successful cyber-attack leading to loss of access to IT systems and services to the whole trust or a specific department. This could be through the deletion or corruption of trust data. The copying of trust data by an external agency, resulting in the compromise of patient confidentiality, reputational damage, an increased risk to patients of their personal wellbeing.</td>
<td>9</td>
<td>Low</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>128</td>
<td>Patient safety or staff harm due to call bells not working. The nurse call systems throughout the trust have been assessed. The results show that most systems are in need of replacement as part of the estates capital plan. Some systems are obsolete and there are no spares available but there is a limited stock of components held on site.</td>
<td>8</td>
<td>Low</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>2017/55</td>
<td>There is a risk between using paper charts and an electronic system (EPMA) of duplication/omission/underdose of medication. This is particularly evident at the overlap/handover of two different systems, e.g.: EDIS (A&amp;E) handover to EPMA; metavision (ICU) handover to EPMA; anaesthetics to EPMA (wards).</td>
<td>9</td>
<td>Low</td>
<td>31/10/2019</td>
</tr>
<tr>
<td>2018/17</td>
<td>The national standard is for medicines reconciliation to occur within 24 hours (NICE QS120). Current performance is below this. Only a third of patients have medicines reconciliation started within 24 hours and less than half of patients have medicines reconciliation completed. This is a risk to patient safety as, if discrepancies are not picked up on admission, critical medicines could be missed which could cause harm to a patient and, for other patients, other discrepancies may cause harm major if the reconciliation is delayed.</td>
<td>12</td>
<td>Not specified</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>2018/18</td>
<td>Seven-day service: The pharmacy department is only funded to provide a basic supply service for three hours at the weekend. Due to the lack of capacity during the week and the increased workload at weekends, staff have to stay past the rostered time to finish the work. This results in more lieu time that needs to be taken during the week which takes staff away from clinical duties on the ward.</td>
<td>9</td>
<td>No specified</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>
The research department is currently running at an unprecedented sickness level, combined with maternity leave and secondment leaving the cancer research team at 50% staffing and the research management team at 40% staffing with only one technical expert.

(Source: Trust Corporate Risk Register, June 2019)

The trust maintained an electronic risk register, which recorded all risks. We observed that the risk register was reviewed at board meetings and risk ratings were amended if necessary, according to the mitigations in place to reduce the risk. For example, we saw that the summary hospital-level mortality indicator (SHMI) data had improved and the risk rating was reduced from extreme to high, with a condition it would continue to receive significant attention to ensure improvements continued. The medical director told us that to continue SHMI improvements, there had been integration of the coding teams to improve data collection, junior doctors received training to correctly complete death certificates and every death was scrutinised by the medical examiner.

Information management

The trust used information to gain assurance and measure improvement in the quality of its services.

The trust had an information governance and information security policy and an information governance strategy. The director of strategy and integration was the trust’s senior information risk owner (SIRO) who reported to the board. There was also a Caldicott guardian who was responsible for protecting the confidentiality of patient and service-user information and enabled patient information to be shared when assessed as appropriate. We raised concerns regarding patient identifiable names on the walls of the ward areas. The trust were very responsive and arranged for all names to be removed.

The trust had utilised an electronic programme to implement health roster and e-job plan in March 2019, the executive team had received feedback from staff that the system had improved staff rostering and planning rotas. There was also an electronic bed management system which enabled managers and wards to track the patient’s pathway through the trust and assisted with patient flow.

The director of strategy and integration and the executive team were aware of national information technology risks which included cyber-security. There were several trust policies to support staff with information governance processes. Following the national cyber-attack in 2017, the trust recruited a cyber security manager to strengthen their resilience to any future threats.

To enhance security the trust had achieved the general data protection regulation (GDPR) and ISO27001 information security standard (this requires businesses to take necessary technical and organisational measures to ensure a high level of information security).
The trust reported incidents, including serious incidents as required to the NHS national reporting and learning system (NRLS) and/or the NHS strategic executive information system (StEIS) in line with national guidance. The trust were also proactive and submitted notifications to the Care Quality Commission in a timely manner.

The trust had an embedded digital academy which supported two apprenticeship placements.

During our core service inspection we highlighted concerns that the storage of patient records was not secure. Patient records were kept in unlocked trolleys in areas that the public could access. We were told that the trust had performed a risk assessment and concluded it was a greater risk to lock the trolleys where patient records were stored just in case they were needed in an emergency. The executive team told us to mitigate the risk they would move the trolleys away from public areas where staff would be present. However, on the well led inspection we observed that the trolleys remained in corridors accessible to the public and in areas where staff where not always present. We were therefore not assured that patients records were stored safely.

**Engagement**

The trust included and communicated effectively with staff, there was good engagement with the public.

Managers at all levels shared leadership responsibilities to improve communication and coordinate engagement activities between staff, patients and external stakeholders. It was recognised that the board required more time to facilitate visits to services to talk with staff and patients. A decision was made to reduce public board meetings to bi-monthly which enabled executives and non-executives to visit services in a planned way.

Walk in my shoe’s initiative was in place, which is where a board member is allocated to a staff member to experience their role, this had proven to be extremely useful to enhance both participants knowledge of each other’s roles. Examples of staff shadowed were, but not limited to; clinical coder, x-ray porter, matron, housekeeper, and site coordinator.

The trust held an annual general public meeting, to encourage attendance they changed the time of the meeting from the afternoon to an evening. To increase attendance further, they advertised that a service would present the improvements they had made in the last year and the catering team provided tasters of the food served to patients. This had a positive response and more people had attended in 2018 and 2019.

The trust had a strong volunteer service, who provided administrative assistance, supported patients on arrival to the hospital, and staff in the clinical areas. The trust had recruited a butterfly scheme coordinator who was in the process of recruiting to the ‘butterfly scheme’ this is when volunteers sit with dying patients when they are alone.

The executive team recognised success and those staff who ‘go the extra mile’ over and above the requirements of their role by holding an annual remarkable people wards evening. Last year they received 480 entries. Staff were nominated by patients, colleagues, or visitors, and a judging panel decided on the winners.
We spoke with two governors who explained how passionate the board of governors were to communicate future plans and initiatives with the general public. They achieved this through several platforms, for example, visiting GP surgeries, having a page in a local community magazine and attending neighbourhood events such as; the local village carnival.

The board minutes included patient stories to highlight patient or family’s experiences. For example, feedback was given by a patient’s daughter regarding the support she received when her father was dying. Both the chief executive officer and the chair had personally spoken to the member of staff and given them the employee of the month award.

Social media platforms were utilised by the organisation as a way of sharing information and receiving feedback from staff, patients and the public.

The executive team had invested in a staff wellbeing team, following staff feedback from the staff survey. The aim was to promote and embed a positive staff wellbeing culture within the trust. The team consisted of three members of staff solely dedicated to staff engagement and wellbeing. Although in their infancy the team had listened and acted quickly to staff feedback, and arranged for the height of screens in the restaurant to be lowered to reduce the segregation between staff and visitors. A health and wellbeing event was held which included healthy fruit smoothie drinks for staff, and relaxation areas, if staff were not able to leave the ward areas to attend, drinks were taken to them on the ward areas.

The trust invited service users to provide views on what they believed should be included within the trust’s quality priorities for the year ahead, which informed what was included in the trust’s quality improvement strategy. Feedback was collected from a short questionnaire, and social media forums. Some of the 2019/2020 quality priorities influenced by feedback were but not limited to; the introduction of condolence cards for bereaved relatives, and the introduction of the butterfly scheme.

In April 2019 the trust held the first overarching James Paget Hospital user group which aimed to meet quarterly to enable users to share experiences and get involved in service redesign. For example, the group were involved with educational recruitment processes, and reviewing emergency surgery pathways.

There was a well-established executive led, carer and patient experience committee (CAPE) which reported to the safety and quality governance committee. CAPE met quarterly and received reports from the divisions regarding their patient engagement activities, themes from patient and carer feedback and actions being taken in response. Each month the board of directors received a quality and safety report from the divisions which detailed the actions taken in response.

The trust’s seventh annual health information day was held this year which welcomed nearly 100 people with learning disabilities and their carers. Discussions at the event included, concerns and praise for the hospital, and an opportunity to discuss and amend the hospital passport used for people with a learning disability.

A user led group called the ‘young onset dementia group’ started in January 2019, as a result of the number of referrals the trust’s dementia team received. The group supported patients and relatives and enabled people to support one another and share experiences.

Learning, continuous improvement and innovation
The leadership team worked well with the clinical leads and encouraged divisions to share learning across the services.

The trust had one active mortality alert, which was cerebral-vascular disease, although they were currently reviewing all cases to identify any themes to improve any identified areas of concern. The trust had a past record of being proactive and being aware of their outlier issues before being been notified of any alerts formally by the Care Quality Commission.

The trust had recruited a medical examiner whose responsibility was to review all inpatient deaths in line with the national quality board's 'learning from deaths guidance’. Work closely with the coroner and their department and share learning across the trust.

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 days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>60 days</td>
<td>100%</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></td>
<td>The trust reported that they do not collate this information</td>
</tr>
</tbody>
</table>

Analysis has shown that the trust took an average of 86.4 working days to close a complaint, which contradicts the trust statement that the current performance is 100%.
(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

From June 2018 to May 2019, the trust received a total of 224 complaints. The highest number of complaints were for medical care, with 20.1% of the total complaints, followed by urgent and emergency care (18.8% of the complaints) and surgery (17.4%).

A breakdown of complaints by core service is shown in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>45</td>
<td>20.1%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>42</td>
<td>18.8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>39</td>
<td>17.4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>32</td>
<td>14.3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>19</td>
<td>8.5%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>14</td>
<td>6.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>13</td>
<td>5.8%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>7</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
Throughout our core service inspection frontline staff told us wherever possible they would try to resolve the complaint at source. However, if this was not possible patients were advised of the formal complaints process.

The trust had a high percentage of complaints that had not be responded to and completed in line with the trust target of 60 days. The executive team told us that this had been highlighted to them and when reviewed it was apparent it was a system failure, which was then added to the risk register. Directorates had generally met their investigation response targets to the complaints department, however, due to staff vacancy there was a backlog with getting the final responses out to patients. The director of nursing (DON) had corporate oversight of the patient experience agenda, which included patient advice and liaison services (PALS) and complaints. Actions had been put in place in response to the delayed replies to complainants, for example, more staff were recruited, and the trust had apologised to all patients where responses were delayed.

We reviewed five complaints, the complaint responses addressed the points raised by complainants and outcomes were clearly documented. All replies were signed by the CEO and there was an audit of how the complainant was responded to by letter, call or meeting.

The CEO had sight of all complaints. Learning outcomes from complaints was shared with staff by email, team meetings and newsletter.

**Compliments**

From May 2018 to April 2019, the trust received a total of 771 compliments. The highest number of compliments were for medical care, with 43.7% of the total compliments, followed by surgery (17.9% of all compliments) followed by urgent and emergency care (14.4%).

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 compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>337</td>
<td>43.7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>138</td>
<td>17.9%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>111</td>
<td>14.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>91</td>
<td>11.8%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>28</td>
<td>3.6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>27</td>
<td>3.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>15</td>
<td>1.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>10</td>
<td>1.3%</td>
</tr>
</tbody>
</table>
The trust did not provide a breakdown by subject for compliments received.

(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 had been awarded an accreditation as well as indicating services that were engaged with schemes but had not yet achieved accreditation:

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
<th>Services that are engaged with the scheme but have not yet achieved accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint advisory group on endoscopy (JAG)</td>
<td>Endoscopy</td>
<td>n/a</td>
</tr>
<tr>
<td>Gold standards framework (GSF) accreditation process, leading to the GSF hallmark award in end of life care</td>
<td>None</td>
<td>The trust has commenced the acute hospitals gold standard framework programme to support this transformation of pathway.</td>
</tr>
<tr>
<td>Anaesthesia clinical services accreditation (ACSA)</td>
<td>None</td>
<td>Interest expressed and looking to confirm further support from colleagues and funding.</td>
</tr>
<tr>
<td>Imaging services accreditation scheme (ISAS)</td>
<td>None</td>
<td>The trust is developing a plan for achievement of accreditation with ISAS as part of their quality priorities 2018/19.</td>
</tr>
<tr>
<td>Clinical pathology accreditation and its successor medical laboratories ISO 15189</td>
<td>None</td>
<td>CPA accreditation is currently in place for hot lab at James Paget University Hospital (part of the eastern pathology alliance (EPA)) with a phased approach to UKAS accreditation across the EPA network. ISO 15189: The laboratory is not currently accredited. There is a plan to submit an application to UKAS for</td>
</tr>
</tbody>
</table>
accreditation later this year. Please note these services are hosted by a local trust.

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

The director of transformation and workforce told us an innovation fund was set up in 2018 which enabled rapid process of innovative ideas, for example, the ‘butterfly scheme’ (volunteers sit with dying patients when they are alone) had recently been agreed and was due to be implemented by the end of the year.

The executive team supported a number of workforce initiatives, the trust fostered an inclusive workforce supporting people with learning disabilities to be employed by the trust. We were also told of a programme where the trust ran courses for local school children to have experience of working in a hospital setting to encourage them to choose a career in health.

The trust have responded to patient suggestions and in September 2019 promoted their ‘you said….we did’ initiative. For example, they installed free wi-fi in all areas of the trust, they have introduced ‘Shhh’ posters to remind staff to keep noise as a minimum, the catering department were introducing more child friendly food for the children’s ward and they were decorating the ward areas.

The executive team supported staff and patients to work together to raise awareness around baby loss and miscarriage. Patient advocates shared their personal experiences of what it felt like to lose a baby or suffer a miscarriage, which helped staff to have improved understanding and empathy.

**Acute services**

**James Paget University Hospital NHS Foundation Trust**

Lowestoft Road
Gorleston
NR31 6LA
Tel: 01493452680
www.jpaget.nhs.uk

**Urgent and emergency care**

**Facts and data about this service**
The trust provided the following information about their urgent and emergency care service, which is based at James Paget Hospital:

The emergency floor is located all in one place supporting the emergency pathway. In 2018, the new ambulatory unit (AMBU) was officially opened and now contains a large open planned reception, comfortable and bright waiting room, a GP referral bay area with four trolleys and new and improved clinical treatment areas. The service also includes the Emergency Department (ED), and the Emergency Assessment and Discharge Unit (EADU), a 48 hour ward.

Services are available 24/7, 365 days a year, with the emergency department (ED treating over 80,000 patients each year.

(Source: Acute Routine Provider Information Request – Context acute tab)

Activity and patient throughput

From February 2018 to January 2019 there were 79,881 attendances at the trust’s urgent and emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at James Paget University Hospitals NHS Foundation Trust compared to all acute trusts in England, February 2018 to January 2019

(Source: Hospital Episode Statistics)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in the most recent year compared to previous year. 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

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>18,590</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>59,345</td>
</tr>
<tr>
<td>Referred*</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>658</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Left department*</td>
<td>914</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>283</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td></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)
The accident and emergency department provides services to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, with the population increasing substantially during the summer months with holiday makers.

Patients present to the department by attending the reception area or arriving by ambulance. The hospital has a designated air ambulance helicopter-landing pad.

The department has facilities for assessment, treatment of minor and major injuries and a separate children’s accident and emergency service. The accident and emergency department is a member of the regional trauma network and provides hyper acute stroke services.

The service was last inspected in August 2015 when it was rated as Good overall. Safe Effective, Caring and Responsive were rated as Good and Well led was rated as Outstanding.

Our announced inspection included the ED, the EADU, and the AmBU.

During our inspection we spoke with 29 members of staff of all grades including; nursing, therapy, medical, housekeeping and reception staff. We also spoke with 13 patients and observed care in all areas of the department.

We reviewed trust policies and standard operating procedures and the medical/nursing notes and prescriptions of 20 patients.

Is the service safe?

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

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

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention (level 2)</td>
<td>56</td>
<td>58</td>
<td>96.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>54</td>
<td>57</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>54</td>
<td>58</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>54</td>
<td>58</td>
<td>93.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>50</td>
<td>54</td>
<td>92.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>53</td>
<td>58</td>
<td>91.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>53</td>
<td>58</td>
<td>91.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>53</td>
<td>58</td>
<td>91.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>52</td>
<td>58</td>
<td>89.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>48</td>
<td>54</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Falls</td>
<td>47</td>
<td>56</td>
<td>83.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical gases</td>
<td>45</td>
<td>54</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care the trust had an overall mandatory training compliance rate of 90.3% for qualified nursing staff. The 90% target was met for eight of the 13 mandatory training modules for which qualified nursing staff were eligible, and almost met for a further two mandatory training modules.

A breakdown of compliance for mandatory training courses from May 2018 to April 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention (level 2)</td>
<td>29</td>
<td>32</td>
<td>90.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>27</td>
<td>32</td>
<td>84.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>27</td>
<td>32</td>
<td>84.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>27</td>
<td>32</td>
<td>84.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>26</td>
<td>32</td>
<td>81.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>24</td>
<td>32</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>21</td>
<td>32</td>
<td>65.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>17</td>
<td>32</td>
<td>53.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall mandatory training compliance rate of 78.5% for medical staff. The 90% target was met for one of the nine mandatory training modules for which medical staff were eligible, and almost met for a further one mandatory training module.

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

Nursing staff received and kept up-to-date with their mandatory training.

Medical staff received and mostly kept up-to-date with their mandatory training. During the inspection we saw evidence that 84% of medical staff were trained in advanced life support, which explained the lower number of basic life support training figures supplied.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was delivered face-to-face and through an online learning system. The practice development nurse post was vacant at the time of inspection, they would normally be responsible for booking all staff onto training courses and this role was being undertaken by a senior member of the nursing staff in the interim.

Staff also completed training in managing sepsis which included the use of sepsis screening tools and care bundles.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff we spoke with told us that this was comprehensive and gave them a good understanding of the specific needs of these patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training completion was regularly discussed at clinical governance meetings.
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.

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

Safeguarding training completion rates

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

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>55</td>
<td>58</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>55</td>
<td>58</td>
<td>94.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>51</td>
<td>58</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – 3 Yearly</td>
<td>50</td>
<td>58</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>50</td>
<td>58</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>48</td>
<td>57</td>
<td>84.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the trust had an overall safeguarding training compliance rate of 89.0% for qualified nursing staff. The 90% target was met for two of the six safeguarding training modules for which qualified nursing staff were eligible, and almost met for a further one safeguarding training module.

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

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
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<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>28</td>
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<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>21</td>
<td>32</td>
<td>65.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – Annual</td>
<td>12</td>
<td>32</td>
<td>37.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care the trust had an overall safeguarding training compliance rate of 76.6% for medical staff. The 90% target was met for two of the six safeguarding training modules for which medical staff were eligible, and almost met for a further two safeguarding training modules.

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

At the time of inspection medical staff safeguarding children level three compliance had improved to 50% and the department was on a trajectory to achieve 100% by March 2020.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example a staff member spoke of the support and protection offered to a person who attended the ED who was undergoing a gender reassignment process and received some negative comments from others in the waiting room.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. From 1 September 2018 to 10 September 2019 the urgent and emergency service made 17 adult safeguarding referrals and 139 children’s safeguarding referrals. The trust also provided information which showed that 39 adult safeguarding and 70 children’s safeguarding discussions took place to discuss concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the trust’s safeguarding leads and spoke positively about the support they provided. The safeguarding team worked with staff in the emergency department to increase safeguarding awareness.

There were safeguarding policies and procedures in place, which were accessible to staff through the trust’s intranet site. Staff demonstrated a good understanding of the trust’s safeguarding policies and procedures.

The service did not perform any specific urgent and emergency department safeguarding audits. Emergency department attendances for children were screened daily by the safeguarding team, and cases discussed and referred in real time, the service commented that this working directly with staff negated the rationale for additional audits.

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 mostly kept equipment and the premises visibly clean.

The urgent and emergency department monitored infection rates in the department. From July 2018 to August 2019, there were no cases of Clostridium Difficile, Meticillin-sensitive Staphylococcus aureus (MSSA) or Meticillin-resistant Staphylococcus aureus (MRSA reported.

Most areas appeared clean and had suitable furnishings which were clean and well-maintained. A concern was raised by a member of staff regarding the standard of cleaning of the GP room, we spoke to housekeeping staff and reviewed the cleaning records specific for that room. There were several omissions due to the room being in use and housekeeping staff confirmed that they would look at the schedule to change the time when the room was cleaned. When we returned for the unannounced inspection staff confirmed that the room cleanliness had improved.
Cleaning records were not always up to date and did not demonstrate that all areas were cleaned regularly. Following our inspection, the trust supplied the cleaning records for the urgent and emergency department. We reviewed the daily cleaning records for the months June, July and August 2019 and saw that housekeeping staff signed to show when and which areas had been cleaned. There were omissions for some areas, and staff had commented why they did not have access. We also noted that although there was a space for a supervisor to sign to confirm that cleaning had been completed to a satisfactory standard, none of the cleaning records we saw were signed by a supervisor, which indicated that cleaning was not checked.

The service performed ad hoc environmental audits (sometimes weekly and others fortnightly) and we saw that results from June to August 2019 ranged between 95% and 98%. The service did not provide a compliance target rate.

Cleaning products were safely locked away to prevent unauthorised use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw good practice relating to hand hygiene, including staff bare below elbows, and use of sanitising hand gel. Hand hygiene technique was displayed around the department to help remind staff and visitors how to clean hands effectively. Sanitising gel dispensers and sinks with soap were available throughout the department and we saw staff use these routinely.

Curtains around bays were disposable and replaced every three months to help prevent cross contamination.

Handwashing audits were performed monthly with results ranging between 82% and 96% with ad-hoc ‘glow and tell’ assessments at 90% the service did not provide a compliance target. The glow box uses ultra violet light to areas where contamination is still present after handwashing.

Managers’ supported infection prevention and control quality audits. Audit results were discussed monthly in the departmental governance meetings with plans to improve performance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We reviewed a range of equipment (29 pieces) and the majority (22) had green I am clean stickers showing the date of cleaning since last use.

**Environment and equipment**

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

The layout of the emergency department (ED) was adequate but outdated and space was at a premium. The ED area contained a GP assessment room and a ‘meet and greet’ (triage) room within the main waiting area, a see and treat area with five cubicles, a ‘minors’ treatment area with seven bays, four majors’ cubicles and three resus bays, a clinical decisions unit (CDU) with two three bedded bays where patients remained overnight.

The mental health assessment room was comfortably furnished and specifically designed for people who presented with a mental health problem. The room was situated away from the main treatment areas to offer people privacy and a safe environment with no ligature or self-harm risks, two exits, with privacy windows and a strip panic alarm around the room. This complied with quality standards set by the Royal College of Psychiatrists psychiatric liaison accreditation network.

The children’s waiting room was separated from the main waiting area within the department with audio and visual separation from the adult section, and a separate treatment and designated
resuscitation room for children. Entrance in and out of the children’s ED was controlled by a locked
door which enabled staff to monitor who was entering or leaving the department.

Staff were aware that the ED was not optimised to support good patient flow due to the limited
space. Senior staff spoke of a plan to improve the ED area, this was dependent on a funding
application.

The emergency assessment and discharge unit (EADU) was next to the ED with the ambulatory
unit (AmBU) connected to the EADU. Ambulatory care is same day care which means that
patients were assessed, diagnosed, treated and able to go home the same day, without being
admitted into hospital overnight. The AmBU was newly opened in 2018 and was a bright airy
space with its own waiting room, separate cubicles and a large area with reclining chairs.

There was easy access to the main hospital from all areas, which meant easy access to diagnostic
departments, for example; x-ray and to refreshments.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was
available in all areas and mostly fit for purpose, apart from the paediatric resuscitation bag which
contained an out of date item and was missing daily check signatures in April and June 2018
although they had been consistent since then. The out of date item was escalated to the senior
staff who immediately organised a replacement. We saw daily checklists were completed in all
areas without omission, but as the paediatric checks had not identified the out of date item we
were not assured that all staff were vigilant in the checking process.

The service had enough suitable equipment to help them to safely care for patients. All 19
electrical items we reviewed had evidence of regular electrical and maintenance checks and none
were found to be out of date.

Staff disposed of clinical waste safely. Staff used the colour coded bins for disposal of clinical and
non-clinical waste. Sharps bins containing used needles and other sharp objects were correctly
signed and dated which helped staff determine when they should be replaced.

Assessing and responding to patient risk

Staff completed risk assessments for each patient although this was not always done in a
timely manner. They removed or minimised risks and updated most of the assessments.
Staff identified and quickly acted upon patients at risk of deterioration.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all five of the Emergency Department Survey
questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse? 6.5 About the same as other trusts

Q33. In your opinion, how clean was the emergency department? 9.0 About the same as other trusts

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? 9.8 About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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

**Ambulance – Time to initial assessment from April 2018 to March 2019 at James Paget University Hospitals NHS Foundation Trust**

![Graph showing median time from arrival to initial assessment](image)

The median time from arrival to initial assessment was consistently better than the overall England median in all 12 months from April 2018 to March 2019, with the average time ranging from four to five minutes.

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

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

**James Paget Hospital**

From May 2018 to January 2019 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at James Paget Hospital was fairly stable with a rate of 60% or more. However, from January to March 2019 the rate declined, showing an improvement.
The highest percentage was in May 2018 with 72.2%. This improved in the most recent month, April 2019 when 49.3% of ambulance journeys had turnaround times over 30 minutes.

The highest proportion of journeys with turnaround times over 60 minutes was observed in February 2019.

**Ambulance: Number of journeys with turnaround times over 30 minutes - James Paget Hospital**

![Graph showing number of journeys with turnaround times.

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - James Paget Hospital**

![Graph showing percentage of journeys with turnaround times.

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From May 2018 to April 2019 the trust reported 409 “black breaches”, with low numbers in the summer and early autumn and high numbers in the winter period. The number of black breaches reported peaked in March 2019 to 108, with 328 occurring from 25 December 2018 to 26 March 2019.
The trust noted that the breaches occurred when ambulances were unable to off load in the emergency department due to issues with physical space and patient flow within the department. They stated that patient flow within the department and the wider trust had been impacted by the increasing demand for their services. Escalation polices and standard operating procedures had been developed to manage flow and ambulance off loads. The department co-ordinator/navigator was based at the ambulance entrance and had good oversight of those patients who had not yet been allocated a cubicle space within ED.

The trust reported that the ambulance entrance at the trust was space constrained and that they were currently unable to increase the physical space in this location. However, they had a phased development in place, with phase one and two completed with the opening of ambulatory care unit (AmBU) in 2018.

The next phase was to increase the number of major cubicles in order to manage the increasing demand for the trust’s services. A request for funding has been submitted to NHS England/Improvement and the trust was awaiting a response. Plans were being developed as an interim measure which would utilise space yet to be vacated to create a larger off load area. Staff saw patients in the corridor and in the ambulance when necessary to assess and prioritise patient risk.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Staff completed risk assessments for patients on arrival/admission (whichever was appropriate), updated them when necessary and used recognised tools for example; frailty assessments, and modified early warning scores.

There appeared to be some confusion within ED as to what constituted streaming and triage. Patients were initially ‘streamed’ by a nurse practitioner to a specific area of the department for example the ED or the AmBU. During the streaming process all patients received an initial verbal assessment by a healthcare practitioner within 15 minutes of arrival, although this did not include
any physical observations such as blood pressure or temperature monitoring. Patients were then ‘triaged’ in the ‘meet and greet room’ where further information was obtained and physical observations performed if appropriate and recorded on paper records. Staff used the initial streaming contact as the triage time on their electronic system however the initial streaming did not conform to NHS England and NHS Improvement Clinical Streaming in the Accident and Emergency (A&E) Department guidance (Gateway document 06842 published July 2017) which states that ‘streaming will typically involve taking a brief history and performing basic observations if appropriate, and ‘streaming should include calculation of an early warning score e.g. the national early warning score (NEWS) for adults or paediatric equivalent for appropriate patients. Early warning scores should be part of the assessment of acuity and not the sole basis for streaming decisions. We had no concerns regarding the safety of patients but were concerned that triage and streaming times were not clear representations of the patient flow. We raised this with the senior management team who were going to review their streaming/triage process.

The reception staff were trained in using a ‘red flag’ criteria to immediately highlight attending patients to nursing and or medical staff, who may be seriously unwell. The criteria included patients; currently fitting, floppy child, severe shortness of breath, facial swelling with airway compromise, altered conscious level, major bleeding, chest pain, chemotherapy patients, deformity of limbs or digits, severe pain, non blanching rash, abrupt onset of a headache, and history of unconsciousness.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the Modified Early Warning Score (MEWS) and the Paediatric Early Warning Score (PEWS) to monitor and identify deteriorating patients. MEWS scores were available to review on the electronic patient system within the ED for all staff with access and this enabled the lead consultant and senior nursing staff to have oversight of any deteriorating patients.

There were paediatric nurses within the ED at all times, and access to the necessary skills and expertise including advanced life support. All ED nurses received paediatric basic life support training as part of their annual updates; with some also having paediatric intermediate life support (PILS) or the European paediatric advanced life support (EPALS) as higher level training.

Both the adult and children’s’ department operated a triage system. Patients’ presenting to the departments either by themselves or via ambulance were treated in priority dependent on their condition. Triage systems aimed to reduce risk by assessing patients and seeing them in order of clinical priority, rather than order of attendance.

We saw appropriate screening tools for sepsis used throughout the department. There was an escalation policy in place for patients with presumed or confirmed sepsis who required an immediate review and the service performed quarterly audits of sepsis management. The results of the audit from March 2019 to May 2019 which sampled 50 patients with a diagnosis of possible infection showed that of the 50 patients screened, 50 were diagnosed with sepsis and 44 (88%) received intravenous antibiotics within one hour. We saw examples of patients receiving antibiotics within the recommended sepsis pathway times.

Staff shared key information to keep patients safe when handing over their care to others. We observed staff using a standard process when patient details were being handed over which provided details of their attendance, diagnostic tests and results, clinical treatment plan and where available discharge arrangements.

Staff had had access to the mental health liaison team based on site between the hours of 9am and 8pm Monday to Friday although there were plans to extend this to 24 hours. Staff knew where
they were based and how to make urgent referrals. Staff told us that they got timely response to referrals. Out of these hours staff contacted the local NHS Mental Health Crisis team.

Staff knew about and dealt with any specific risk issues. We saw that clinical assessments were used for patients to record and act on identified risks such as; reduced skin integrity, falls, safeguarding vulnerability or delirium (confusion).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Formal mental health risk assessments were in place for both adults and children. We saw that these assessments were detailed, comprehensive, personalised and sensitive.

Staff in ED had access to ligature scissors should they be required.

The trust had major incident and business continuity plans in place. Both documents set out staff roles and responsibilities for the urgent and emergency department in the event of a major incident both internally or externally. The documents were updated on a regular basis and version controlled. Staff we spoke with were aware of the specific role that their department and other urgent and emergency areas would play and the service provided multidisciplinary study days and ‘table top’ exercises twice a year with the last being in July 2019. These events covered a range of topics including but not limited to; triage, decontamination training and the ED plan.

**Nurse staffing**

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

The emergency assessment and discharge unit (EADU) and the ambulatory unit (AmBU) had enough nursing staff of relevant grades to keep patients safe. The ED had a significant number of vacancies (12) out for recruitment. The ED used a small cohort of regular agency nurses and bank staff (some of whom were retired ED staff) to fill vacant shifts. All agency and bank staff had received a full induction to the department.

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. Emergency nurse practitioners (ENPs) and nurse associates (NAs) cared for patients in the minor injury area and supported medical staff caring for patients in the majors area.

Registered children’s nurses worked in the children’s accident and emergency department and nurses rotated with the children’s ward to enhance skill retention. There was a children’s nurse available in the ED at all times in line with Royal College of Nursing guidance.

**Trust level**

The table below shows a summary of the nursing staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.

<table>
<thead>
<tr>
<th>Urgent and emergency care annual staffing metrics</th>
<th></th>
</tr>
</thead>
</table>

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Post-inspection Evidence appendix template James Paget University Hospital NHS Foundation Trust
<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>164</td>
<td>13%</td>
<td>12%</td>
<td>5.2%</td>
<td>4,143 (3%)</td>
<td>9,401 (8%)</td>
<td>914 (&lt;1%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>67</td>
<td>18%</td>
<td>13%</td>
<td>5.9%</td>
<td>914 (3%)</td>
<td>914 (8%)</td>
<td>914 (&lt;1%)</td>
</tr>
</tbody>
</table>

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

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy or turnover.

The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants on all shifts on the EADU and the AmbBU matched the planned numbers. Following our inspection we reviewed the ED staff rota for the four week period 15 July to 11 August 2019 which showed 14 unfilled registered nurse shifts and 48 unqualified staff shifts. Senior staff were aware that nurse staffing numbers had fallen and were actively recruiting to fill 12 vacancies.

The nursing staff sickness rates was higher than the trust target, but senior staff reported that this figure included staff on long term sickness. We saw that sickness was monitored in the governance meeting minutes and that there was continuing monitoring and support for staff off sick.

Sickness rates

![Sickness rate - qualified nurses, health visitors and midwives](image-url)
Monthly sickness rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed a downward trend from December 2018 to April 2019.

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

Bank and agency staff usage
Monthly bank hours from May 2018 to April 2019 for qualified nurses showed an upward trend from May 2018 to September 2018.

Monthly agency hours from May 2018 to April 2019 for qualified nurses, health visitors and midwives were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The service used bank and agency staff to back fill gaps in staffing and confirmed that they used only regular staff who had worked in the department and had completed the necessary induction and competencies.

Medical staffing

Trust level

The table below shows a summary of the medical staffing metrics within urgent and emergency care at trust level compared to the trust’s targets, where applicable. Please note that the trust
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<tr>
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<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>164</td>
<td>13%</td>
<td>12%</td>
<td>5.2%</td>
<td>10,015 (14%)</td>
<td>2,341 (3%)</td>
<td>-342 (&lt;0%)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>34</td>
<td>14%</td>
<td>25%</td>
<td>2.9%</td>
<td>10,101 (14%)</td>
<td>2,066 (3%)</td>
<td>-335 (&lt;0%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover or locum use.

Please note that the negative unfilled hours in the table above are due to the trust over-recruiting at a junior level to assist with the safe management of gaps to meet service demand. This is on a fixed term contract for 12 months. This supported the rota and avoided the use of agencies.

**Vacancy rates**

![Vacancy rate - medical staff](image)

Monthly vacancy rates from May 2018 to April 2019 for medical staff were not stable and may be subject to ongoing change.
The service had enough medical staff to keep patients safe but did not always match the planned number on all shifts in each department. The trust over-recruited middle grade staff to assist with the safe management of gaps to meet service demand. The service was in the process of writing a business case for a further six middle grade staff so that they could ensure there were two on every night.

**Sickness rates**
Monthly sickness rates from May 2018 to April 2019 for medical staff showed a shift from November 2018 to April 2019.

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

Sickness rates for medical staff were low.

**Bank staff usage**
Monthly bank hours from May 2018 to April 2019 for medical staff showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

Staffing skill mix

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

As of February 2019, the proportion of consultant staff reported to be working at the trust was similar to the England average while the proportion of junior staff (foundation year 1-2) was lower.

Staffing skill mix for the 27 whole time equivalent staff working in urgent and emergency care at James Paget University Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>28%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>21%</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 always had a consultant on call during evenings and weekends.
The ED consultant was present on site 8am to 10pm Monday to Friday and then on call off site. Saturdays and Sundays a consultant was on site 8am to 4pm then on call off site.

There was an ED registrar doctor on site and available 24/7. They were contactable by pager for all areas of the trust. Monday to Friday 9am to 5pm. An ‘on call’ paediatric consultant was available on site or contactable by pager or mobile phone out of normal hours (between 5pm and 9am) weekdays and at the weekends.

Staff confirmed that consultant staff were available and that they were responsive when called if not on site.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The trust had the ability to schedule a consultant locum shift at the weekend 4pm to 10pm if required.

**Records**

**Staff kept detailed records of patients’ care and treatment. Records were not always clear or stored securely, although they were up-to-date, and easily available to all staff providing care.**

The urgent and emergency service used a mixture of computer and paper based records. Patient notes were generally comprehensive, and most staff could access them easily. We reviewed 20 patients’ records during our inspection. These were mostly legible and accurate and contained the right details about each patients’ care including the presenting complaint, allergies, pain and clinical observations. However we did see one set of notes in ED without the history takers details, date or times and another with illegible writing. Two patient records on the EADU had reviews that were illegible and the doctors signature was not legible. It was difficult to assess how complete the records ED were, due to them being part paper and part computerised. Not all entries were timed or signed, and electronic and paper records did not always match, for example, assessment times. Assessments were ticked as being completed on the computer but not visible in the paper notes in six of the 20 records we looked at.

Patient records contained details of other non-physical conditions such as mental health needs and hidden disabilities where applicable. Staff were confident that patient records contained all the information they required.

We saw risk assessments such as early warning scores and pressure area care being completed appropriately and within the required timescales.

We saw antimicrobials being prescribed with clinical indications, dose and duration of treatment within the clinical records.

We reviewed patient discharge summaries and all were comprehensive. Discharge summaries were shared by the trust with other relevant professional such as GPs and care homes.

Computer systems were used to monitor patients through their care pathway in the department. The computer system enabled staff, from the front door to managers, to view each area of the department individually or to see a complete overview of the department.

When patients transferred to a new team, there were no delays in staff accessing their medical records.

The ED used an emergency department handover sheet at the change of each shift, which detailed but was not limited to; key information such as staffing allocations, forecast of any
concerns including events, medication concerns, delayed admission issues and controlled drugs checks. This was kept with the safer staffing rota so that all staff had access to the handover sheet.

Patient paper records were stored in unlocked cabinets usually opposite the nurses’ station. This meant that anyone passing by could remove notes and look at them, this was escalated to the senior management team.

The service performed ad hoc records audits. We reviewed an audit of seven patient records from April 2019 which showed an overall compliance rate of 93%. The trust did not provide a compliance target rate.

**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. Medicines were stored in locked cabinets in locked rooms. Keys to access medicines were held by designated qualified members of staff.

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

Staff stored and managed medicines and prescribing documents in line with the trust’s policy. We checked a range of medicines in different areas of the urgent and emergency department. Medicines were stored neatly and were within expiry date. Controlled drugs were checked daily to help make sure stock levels were correct.

Intravenous (IV) fluids were appropriately labelled and stored securely in all areas other than the children’s’ ED where we found fluids containing potassium were incorrectly stored with the rest of the IV fluids. This posed a risk of IV fluids containing potassium being used by mistake and was not in line with best practice. This was escalated to senior staff who immediately rectified the storage of potassium in line with trust’s guidelines.

Staff followed current national practice to check patients had the correct medicines. Doctors prescribed and dispensed medicines in line with their registration. Nurses with prescribing rights could prescribe and dispense a limited range of medicines. Nurses without prescribing rights issued a small number of medicines such as paracetamol using patient group directions (PGDs). Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Pharmacy staff visited the urgent and emergency areas weekly to check stock and expiry dates and remove any out of date or unwanted items. The ED kept a small stock of ‘to take away’ (TTA) medicines which were dispensed by staff during out of hours periods.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. The service had a standard operating procedure for the prescription of sedation medicines for those patients presenting with mental health conditions to ensure best prescribing practices.
Incidents

The service generally managed patient safety incidents well however we were concerned that staff did not always recognise and report incidents and near misses 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 we spoke with knew what incidents should be reported and how to report them on the electronic reporting system. For example, incidents of violence and aggression from patients or their relatives, falls, and medication concerns. However, we were not assured that all staff reported incidents appropriately as we heard about a patient fall in ED on the first day of our inspection but this had not been reported as an incident until we raised it as a concern with senior staff on the second inspection day. Senior staff told after our inspection that this had been followed up and reported as an incident.

Managers told us they had an open reporting process to learn from incidents or near misses.

We saw evidence of shared learning regarding delayed diagnoses from the ED also shared from other departments.

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 May 2018 to April 2019, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from May 2018 to April 2019. All four of these were treatment delays (one in October 2018 and three in March 2019, the three in March were due to patients waiting in ED longer than 12 hours and one safeguarding concern (October).

(Source: Strategic Executive Information System (STEIS))

We reviewed the root cause analysis (RCA) of the serious incidents and saw that they were robust, detailed, learning was noted and action plans identified and shared with the rest of the team.

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. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care
services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff and managers, we spoke with knew and understood their responsibilities in relation to the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with provided examples of feedback following incidents. Senior staff shared key messages and learning at handovers and by email. These included incidents that had happened in other departments of the hospital.

Staff met to discuss the feedback and look at improvements to patient care. Senior staff discussed incidents during the divisional operations meeting and the divisional board meetings.

There was evidence that changes had been made as a result of feedback. For example, staff shared the learning and changes that had been made when checking patients discharge arrangements for transport home following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw this was evident in an investigation report we reviewed.

Managers debriefed and supported staff after any serious incident. Staff told us that the managers were very supportive following any incident and although there was not a formal debrief session the managers doors were always open.

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 with a safety thermometer dashboard and an ED service delivery board.

Safety thermometer data was not displayed on EADU as the ward board had been taken down as it needed to be moved following the opening of the new AmBU. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from April 2018 to April 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

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. People’s care and treatment was planned and delivered in line with up to evidence-based guidance and standards set by the National Institute of Health and Care Excellence, The UK Resus Council and the Royal College of Emergency Medicine.

We reviewed nine clinical policies and guidelines during our inspection within the emergency department (ED) and on the trust intranet. Policies were in date, regularly updated and based on NICE and best practice guidelines. These were accessible to staff on the trust intranet.

Senior staff reviewed NICE guidance and we saw that non-compliance was noted for action in governance meeting minutes, for example: CG091 - General Medicine/A&E, Depression in Adults with chronic physical health problem and CG169 - General Medicine/A&E, Acute Kidney Injury: prevention, detection and management. Both had senior staff allocated and timeframes for actions.

Guidance was also reflected in a number of departmental clinical pathways and standard operating procedures. For example, there was a clear pathway in place for patients presenting with a mental health concern. Staff completed a mental health form once the mental health needs were identified at triage, this covered mental capacity, detailed risk assessments and presenting issues. There was a separate form for adults and for children.

Staff protected the rights of patient’s subject to the Mental Health Act and followed the Code of Practice. We saw this in the way they communicated with two patients with mental health concerns.

Staff included referral to the psychological and emotional needs of patients, their relatives and carers at handover meetings. We observed staff discussing this at the board round on EADU.

The trust had successfully piloted an ambulatory emergency care pathway project in EADU, which allowed staff to quickly diagnose and treat patients with acute medical admissions who did not require an overnight stay. The pilot used point-of-care testing (POCT) to provide diagnostic whole blood test results within five minutes which was a significantly quicker turnaround than the traditional results provided by pathology laboratories, which take 90 minutes. Initial results had shown a 40.8% reduction in patient length of stay, 59 saved bed days and 85% of patients seen and discharged on the same day during a six month period in 2018.

An ED point of care testing pilot had commenced, and a business case to assess the full implementation of ambulatory care had been developed by the project leads.

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. Food was available for those attending the emergency department and the AmBU and catered for a range of needs including vegetarian, halal and gluten free. For more specific needs such as vegan or celiac patients, housekeepers contacted the hospital kitchen who provided a meal which met these requirements.

Breakfast, lunch and dinner were provided for patients in the emergency admission and discharge unit (EADU) and ward16.
In between these times housekeepers performed regular ‘rehydration rounds’ where they ensured that both staff and patients/visitors were offered refreshments.

The trust had a commercial shop, cafeteria and restaurant outlets where staff, visitors and patients could purchase food and drink.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Staff mostly completed patients’ fluid and nutrition charts where needed although the April 2019 ED records spot check audits showed that these were not always consistently completed. Of the 20 patient records we reviewed only three had fluid balance charts and all were complete.

Staff used the nationally recognised Malnutrition Universal Screening Tool (MUST) to monitor patients at risk of malnutrition. The MUST is a five step screening tool to identify adults who are malnourished or at risk of malnourishment or obese and includes management guidelines. All patient notes we reviewed who were admitted had a MUST completed.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. Staff confirmed that they were able to refer directly and that referrals were responded to quickly.

**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 and gave pain relief in line with individual needs and best practice. We spoke with patients in the waiting areas as well as in the cubicles, they told us staff offered pain relief at regular intervals.

Patients received pain relief soon after it was identified they needed it or they requested it. We did not see any patients left in pain and they were regularly asked by staff whether they required any pain relief.

Staff prescribed, administered and recorded pain relief accurately. In records we reviewed we saw evidence that pain was discussed during initial assessment and pain relief provided. However, there was very little evidence in patient records to show that follow-up pain scores were recorded to assess the efficacy of the pain relief.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.4 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.7 for the question “Do you think the hospital staff did everything they could to
help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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 well in national clinical outcome audits and managers used the results to improve services further. For example an audit of children streamed to the GP service identified the times when the GP service was most used and the service were reviewing the GP operating hours.

Managers carried out a local audits and the department had a comprehensive, active audit programme. These included national audits requested by the Royal College of emergency Medicine (RCEM). Others were local audits or were based on NICE guidance.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, James Paget Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for four standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 59.4%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 91.7%; UK: 77.0%
- Standard 5b (fundamental): If not already given before arrival to the emergency department, steroids should be given within 4 hours (moderate). This department: 50.0%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed according to guidelines. This department: 82.4%; UK: 52.0%.

The department was not in the lower UK quartile for any standards.

The department’s results for the remaining three standards were all within the middle 50% of results:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 12.5%; UK: 19.0%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 15.6%; UK: 26.0%.
- Standard 5a (fundamental): If not already given before arrival to the emergency department,
steroids should be given within 60 minutes of arrival (acute severe). This department: 28.6%; UK: 19.0%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, James Paget Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for all four standards:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 20.0%; UK: 11%.
- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 32.0%; UK: 8%.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 28.0%; UK: 12%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 44.0%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, James Paget Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 84.2%; UK: 64.6%.

The department was not in the lower UK quartile for any standards:

The department’s results for the remaining seven standards were all within the middle 50% of results:

- Standard 1: Respiratory rate, oxygen saturations (SaO\textsubscript{2}), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 68.4%; UK: 69.1%.
- Standard 3: \text{O}_2 was initiated to maintain SaO\textsubscript{2}>94% (unless there is a documented reason not
Standard 4: Serum lactate measured within one hour of arrival. This department: 65.8%; UK: 60.0%.

Standard 5: Blood cultures obtained within one hour of arrival. This department: 44.7%; UK: 44.9%.

Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 55.3%; UK: 43.2%.

Standard 7: Antibiotics administered: Within one hour of arrival. This department: 44.7%; UK: 44.4%.

Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 7.9%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

Trauma Audit and Research Network (TARN)

James Paget Hospital

The table below summarises James Paget Hospital's performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a non-medical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Ascertainment</td>
<td>74.7 – 88.2%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</td>
<td>43 mins</td>
<td>Takes longer than TARN aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</td>
<td>100.0%</td>
<td>Higher than the TARN aggregate</td>
<td>n/a</td>
</tr>
<tr>
<td>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care  
*(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*

<table>
<thead>
<tr>
<th></th>
<th>0.0%</th>
<th>Lower than the TARN aggregate</th>
<th>Not met</th>
</tr>
</thead>
</table>

Risk-adjusted in-hospital survival rate following injury  
*(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)*

<table>
<thead>
<tr>
<th></th>
<th>0.4 additional survivors</th>
<th>Similar to expected</th>
<th>Met</th>
</tr>
</thead>
</table>

(Source: TARN)

Staff were proud of their performance in the TARN audit but were not complacent and strived to improve on their performance.

Managers used information from the audits to improve care and treatment. For example; the ‘Sepsis Management According to Sepsis 6’ audit identified that sepsis stickers were not always used to identify patients at high risk of sepsis, and this was addressed in the action plan with a plan to re audit to check compliance.

Managers shared and made sure staff understood information from the audits. Information from audits was shared with staff and we saw examples of this in e-mails and newsletters.

Improvement was checked and monitored with several of the audits having repeat audits planned to confirm improvement. For example the ED Safety Sheet audit and the Procedural Sedation in Adults RCEM Audit.

Unplanned re-attendance rate within seven days

The service had a lower than expected risk of re-attendance than the England average. From April 2018 to March 2019, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average.

The trusts performance peaked in April 2018, when the trust had a rate of 5.6% compared to an England average of 7.1%.

From September 2018 to March 2019, the trust’s performance was continuously at 7.0%.

Unplanned re-attendance rate within seven days - James Paget University Hospitals NHS Foundation Trust
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. The service encouraged development and told us about staff undertaking extended training to become; clinical support assistants, assistant practitioners, physician associates, advanced clinical practitioners and emergency nurse practitioners.

Managers gave all new staff a full induction tailored to their role before they started work. Newly qualified nurses undertook a preceptorship period, which included support from the trust and compulsory study days covering key clinical skills. The emergency assessment and discharge unit (EADU), and the ambulatory care unit (AMBU) offered a six month rotation for nursing staff to ensure that nurses received a broad experience.

Appraisal rates

Managers supported staff to develop through regular, constructive clinical supervision of their work. Senior staff provided daily clinical supervision and regular theoretical learning opportunities for multidisciplinary staff.

Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor effectiveness. Staff we spoke with confirmed that they had received an appraisal within the previous 12 months.

From May 2018 to April 2019, 77.2% of required staff in urgent and emergency care received an appraisal compared to a trust target of 80%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - A&E quality indicators)
<table>
<thead>
<tr>
<th>Administrative and clerical</th>
<th>17</th>
<th>17</th>
<th>100.0%</th>
<th>80%</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>34</td>
<td>43</td>
<td>79.1%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>36</td>
<td>50</td>
<td>72.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Registered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional professional</td>
<td>0</td>
<td>3</td>
<td>0.0%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Scientific and technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>114</td>
<td>77.2%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

The appraisal completion target was met by two staff groups. Nursing staff did not meet the 80% target, with 72.0% of staff receiving an appraisal.

The trust did not supply detailed medical staff appraisal data; however, they did provide the trust wide statement below:

For 2018/19 the trust achieved 100% compliance for category 1 medical appraisals. Over this time period, 12% of the total number of doctors eligible for appraisal were classified as category 2 which is approved incomplete or missed appraisal due to qualifying criteria e.g. maternity leave. There were no doctors in category 3 (unapproved incomplete or missed appraisals).

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

There was no clinical educator to support staff learning and development at the time of our inspection due to vacancy, the role was being undertaken by a senior member of staff until a new clinical educator was in post.

Managers provided opportunities for staff to attend the away days or had access to full notes when they could not attend. Staff we spoke with confirmed that they found the away days useful and commented that they worked better than the previous regular team meetings which were often difficult to attend due to time constraints.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with confirmed that training needs were identified at their appraisals or they could request specific training they had an interest in. Two staff told us that it was sometimes difficult to fit in the regular updates for specific training during work hours due to short staffing issues.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were opportunities to develop careers in emergency or advanced nurse practitioner roles. Nurses in these roles told us they were given good support and protected time to study and gain new skills.

Managers made sure staff received any specialist training for their role. A member of staff with advanced paediatric life support (APLS or equivalent) training was on duty at all times. Within the paediatric team in the department this was 100%.

Managers identified poor staff performance promptly and supported staff to improve. Managers provided one to one support and teamed poor performing staff with experienced and senior staff to monitor and supervise.
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. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw good multidisciplinary working practices within the department. Nurses and doctors spoke highly of each other and we observed a cohesive relationship when dealing with patients. Staff told us that they liaised with other departments to gain specialist input. Occupational therapists and physiotherapists attended the ED daily to assess and treat patients.

Staff in all of the urgent and emergency care areas worked across health care disciplines and with other agencies to care for patients. During our inspection we saw staff working together as a team to assess and plan ongoing care and treatment when people were moved between teams or departments, including referral and discharge.

Staff referred patients to the psychiatric liaison services for mental health assessments when they showed signs of mental illness, health, or depression. There was an adult mental health psychiatric liaison manager based on site who attended the department daily and assisted in coordinating care for those patients with mental health needs.

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 and diagnostic services, 24 hours a day, seven days a week. This included specialist diagnostic services, for example, computerised tomography (CT) scans out of hours.

Psychiatric liaison services attended the ED daily at the start of the shift and were available from 8 am until 12 midnight. Between midnight and 8 am staff called the crisis team but admitted that there was often a gap between 5 am and 8 am. Staff had secured funding for a 24 hour service from March 2020.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in each area of the department. We saw examples of health promotion literature on display within the department such as smoking cessation, healthy eating, mental health, alcohol and substance misuse. Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients we spoke with told us staff discussed lifestyle changes with them whilst under their care for example reducing smoking and wearing heavy duty gloves in future to avoid hand injury during manual work.

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. A trust policy provided staff with information about consent processes and the principles of the Mental Capacity Act (MCA) 2005. The policy also included information about obtaining consent from patients with learning difficulties and communication difficulties.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Consent in the ED was obtained on either a verbal or an implied basis. If patients were not well enough to provide consent, staff discussed care or treatment with relatives, loved ones or made life saving decisions in the patient’s best interests.

We saw the use of green MCA assessment stickers in patients notes, indicating to staff that an assessment had been performed and the outcome was documented.

Staff mostly made sure patients consented to treatment in line with legislation and guidance and based on all the information available. However, we saw one written consent form for a surgical procedure in a patients notes in EADU which although signed by clinician and patient, was poorly completed with no documented benefits or risks. This was raised with the ward manager who told us that they rarely had surgical patients on the unit but that they would check this in future. Two consent forms for medical procedures were fully completed.

Staff gave patients the information they wanted or needed to consent to procedures in ways they could understand. We observed a member of staff explaining a splinting procedure to a patient and obtaining verbal consent to proceed. The staff took time to make sure that the patient understood why the procure was necessary and the risks associated.

Two patients we spoke with described how they had consented to a procedure and were confident that they had been fully informed of the risks and benefits.

Staff we spoke with understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Mental Capacity Act and Deprivation of Liberty training completion

All staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards and found it useful.

Trust level

The trust advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust set a target of 90% for completion of MCA/DoLS training.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>51</td>
<td>58</td>
<td>87.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care the target was not met for either of the two adult safeguarding modules incorporating MCA/DoLS training for which qualified nursing staff were eligible.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care the target was not met for either of the two adult safeguarding modules incorporating MCA/DoLS training for which medical staff were eligible.

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

Staff we spoke with 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. They knew who to contact for advice and found them supportive and helpful.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). There was a mental health liaison who assisted with capacity assessments and support from the safeguarding team for DoLS applications.

Managers monitored how well the service followed the Mental Capacity Act through regular contact with the mental health liaison team.

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 examples of staff maintaining patients’ dignity and privacy. All staff made sure patients were fully covered with blankets before moving them out of cubicles.

Patients said staff treated them well and with kindness. Feedback that patients provided was “staff friendly and do their best”, “Doctors are really good”.

Feedback left on the NHS review site was generally positive, for example, “exemplary care received in both A&E and ACU, treated with dignity respect and compassion at all times”
Staff organised car park release ‘coins’ for distressed and bereaved relatives to ensure that they had easy access out of the hospital without having to return to the pay machines in the main corridor.

Staff went beyond that expected of them in providing compassionate care. We heard about a staff member offering their own personal mobile phone so that a dying patient could speak with their relative abroad. Another example was where staff liaised with external services to ensure that a patient’s pets were looked after whilst he was admitted for urgent surgery.

**Friends and Family test performance**

The 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 85.5% and 95.3% from March 2017 to February 2019.

The data showed a shift, which is an indication of change.

The data also showed two data points outside of the control limits (in July 2018 and February 2019).

Response rates for the A&E friends and family test can often be low. The chart below shows the response rate for this metric. Over the two-year period there was an average of 429 responses per month for this trust.

**James Paget University Hospitals NHS Foundation Trust – response rate March 2017 to February 2019**
Staff followed hospital policy to keep patient care and treatment confidential, however, patient records were not locked away. This had been highlighted in the ward areas on our previous inspection and although the trust had performed a risk assessment for storing patient records in this way, we were not assured that it provided complete confidentiality for patients.

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 this during patients with two patients with mental health concerns admissions.

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. We saw staff taking the time to talk with patients and relatives and offering a gentle touch to the hand.

The hospital chaplain was a regular visitor to the department and staff commented that they were very supportive to patients, relatives and staff when in need of pastoral non-denominational care.

Staff involved the bereavement team following a patient death to provide support to the families of the deceased. This included dealing with the distressing but necessary information on tissue donation where appropriate, how to register a death, and arranging a funeral.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff kept patients covered with a blanket to protect modesty and dignity and ensured curtains were closed when performing any personal care.

Senior staff undertook in house training on breaking bad news and demonstrated empathy when having difficult conversations.

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 staff communicating with patients and their relatives and saw that they were discreet offering advice and 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 saw feedback left on the NHS review website which said “Given explanations and treatment options as well as reassurance, despite a worrying time all staff from paramedics to porters, nursing and medical teams were superb. Sincere, genuine praise and thanks”.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff taking time to explain to patients and their relatives and answering their questions to ensure that they had all the information they needed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. They could do this through the patient feedback cards, through the website or the NHS website.

Staff supported patients to make informed decisions about their care by providing information and signposting to other agencies where appropriate.

A high proportion of patients who gave feedback about the service was positive in the Friends and Family Test survey. The percentage of patients who recommended the service was 89% compared to the England average of 85% although the response rate (6.3%) was lower than the England average of 12.4%

Emergency Department Survey 2016

The trust scored better than other trusts for two of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 22 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>4.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.8</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall experience</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The feedback from the emergency department survey test in August 2019 was mainly positive. The positive themes commented on; treatment and care being of the highest calibre, medical staff being informative and staff being friendly and helpful. Negative themes included long wait times; perceived understaffing and waiting room being uncomfortable and in a poor state with no facilities. There was an action to improve the waiting area in the planned reconfiguration of the ED and staff recruitment was ongoing.

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. The ED ran a scoping exercise prior to the introduction of the GP streaming service, to identify what the local population required in terms of hours of cover and number of clinicians needed. They were able to identify optimum hours for the service with the peak arrivals being from 11am to 5pm. This meant that they worked to provide a service that met the needs of the patient.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no mixed sex breaches during the period from October 2018 to September 2019.

Facilities and premises were appropriate for the services being delivered. There were adequate chairs in the waiting area for people during the periods of time we observed. The ED was easily accessible for patients using wheelchairs and those with other mobility issues. Doorways and corridors were generally kept free of obstacles and allowed patients with reduced mobility, good access to all areas of the ED. A large electronic monitor in the waiting room displayed information about the ED waiting times.

The children’s waiting room and emergency department had a child friendly décor with a selection of toys and books available.

Staff could access emergency mental health support between 8am up to 12 midnight seven days a week for patients with mental health problems, learning disabilities and dementia. Out of these hours they had to use the local crisis team which sometimes meant long delays in accessing support. From March 2020 there was an agreement for 24 hour support.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had systems to identify/highlight patients who needed specialist support, for example, those people living with dementia or a learning disability, there were alerts which flagged on the patient electronic system.

The service had facilities suitable for those with a physical or mobility disability and it was noted that in the main corridor of the hospital there were changing/hygiene facilities for those patients with continence problems.

The trust had key staff to work across services to coordinate people’s involvement with families and carers, particularly for those with multiple long-term conditions based in a ‘hub’ office. These staff included; mental health, dementia, social services, the integrated care team and safeguarding. The urgent and emergency staff worked with the hub staff to ensure that patients’ care was patient centred and co-ordinated.

Managers monitored and took action to minimise missed appointments. Staff called patients who failed to attend the dressing clinic to offer further appointments or advice.

The service relieved pressure on other departments when they could treat patients in a day. The streaming nurse assessed patients at point of entry and if possible referred them to the AmBU where they could be seen and treated in a day to reduce hospital admissions. The ED had a clinical decisions unit which was used for patients who were awaiting results, investigations or who required 24 hour observations or care.
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 were pathways for both adult and children presenting to the ED with mental health needs involving the appropriately trained staff.

The service was part of a newly formed High Intensity User (HIU) multidisciplinary working group to address the clinical and financial impact of a number of patients who were frequent attenders, who may have anti-social behaviour/chaotic lifestyles, and were responsible for a large number of ED attendances. An HIU is defined as those patients with 10 or more ED attendances in a year. The group included members of the local; clinical commissioning group, constabulary, council and community healthcare service. There was a plan to set up a scheme to support the HIU individuals and embed the support needed within the communities. This supported connections across multidisciplinary networks, as well as providing one to one support for patients to enable them to overcome and address some of the reasons they used services inappropriately.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The ED was not specifically designed to meet the needs of patients living with dementia, however, staff made every effort to ‘fast track’ these patients where it was possible. We observed this with ambulance staff bringing a patient living with dementia past other waiting patients to lessen the impact of waiting for the patient. Staff could access specialist or lead nurses to support patients living with dementia, or to provide advice to staff when required.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to dementia and learning disability friendly communication aids and had dementia sensory objects such as ‘fiddle muffs’ and battery powered ‘purring’ cats for patients to stroke.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that an interpretation service was available to communicate with patients whose first language was not English. This was primarily accessed over the phone, but translators could be sourced to speak face to face if required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw this with the menu choices offered to patients.

Staff had access to communication aids to help patients become partners in their care and treatment such as pictorial description cards and a hearing loop.

Children and young people were cared for in the paediatric ED by registered children’s nurses. Occasionally, children and young people with mental health issues or other specialist treatment needs were managed in the minors area or of the main ED if this was more appropriate. At those times staff followed the appropriate standard operating procedure (SOP) and performed a risk assessment. For example, there was only one slit lamp located in the adult ED so if a child or young person with an eye problem presented they were taken to the adult area briefly to use this for examination.

Emergency Department Survey 2016
The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients although not always in line with national standards were better than or similar to England average.

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Data was collected electronically and submitted to a national quality indicator monitors for comparison to other organisations and national standards.

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. The trust consistently met the standard over the 12 month period from April 2018 to March 2019. Over the same period, performance against this standard was better than the England average.

From April 2018 to March 2019 performance against this standard was less than 35 minutes in all 12 months, with a range of 19 minutes (November 2018) to 32 minutes (August 2018).

In the most recent month, March 2019, the median time to treatment was 30 minutes compared to the England average of 65 minutes.

**Median time from arrival to treatment from April 2018 to March 2019 at James Paget University Hospitals NHS Foundation Trust**
Managers and staff worked to make sure patients did not stay longer than they needed to. Staff regularly checked on the electronic system for any hold ups in the patient pathway.

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

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

From May 2018 to April 2019 the trust failed to meet the standard in all 12 months. Over the same period, the trust performed better than the England average in ten out of the 12 months and followed a similar pattern to the England average.

From December 2018 to February 2019, performance deteriorated but this may be due to winter pressures.

**Four hour target performance - James Paget University Hospitals NHS Foundation Trust**

(Source: NHS England - A&E Waiting times)
September 2019 data showed that the trust performance for patients admitted, transferred or discharged within four hours of arrival in the emergency department was 84.8% which was similar to the England average of 85.4%

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From May 2018 to April 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.

From September 2018 to February 2019 performance against this metric showed an overall rise in the percentage of patients waiting more than four hours from the decision to admit until being admitted. However, this was followed by an apparent improvement in performance from March 2019.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - James Paget University Hospitals NHS Foundation Trust**

![Graph showing percentage of patients waiting more than four hours from decision to admit until being admitted from May 2018 to April 2019.](image)

The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted by month over this time period:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2018</td>
<td>67</td>
</tr>
<tr>
<td>June 2018</td>
<td>41</td>
</tr>
<tr>
<td>July 2018</td>
<td>94</td>
</tr>
<tr>
<td>August 2018</td>
<td>51</td>
</tr>
<tr>
<td>September 2018</td>
<td>34</td>
</tr>
<tr>
<td>October 2018</td>
<td>59</td>
</tr>
<tr>
<td>November 2018</td>
<td>46</td>
</tr>
<tr>
<td>December 2018</td>
<td>98</td>
</tr>
</tbody>
</table>
The highest numbers of patients waiting over four hours were in January (198), February (194) and March 2019 (136).

(Source: NHS England - A&E SitReps).

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

Over the 12 months from May 2018 to April 2019, three patients (all in March 2019) waited more than 12 hours from the decision to admit until being admitted.

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

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

The number of patients leaving the service before being seen for treatments was low.

From April 2018 to March 2019 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average.

The highest percentages of patients that left the trust’s urgent and emergency care services before being seen for treatment were observed in July 2018 (2.0%), August 2018 (2.0%) and March 2019 (2.0%).

From April 2018 to March 2019 performance against this metric followed a similar pattern to the England average.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - James Paget University Hospitals NHS Foundation Trust
Median total time in A&E per patient (all patients)

From May 2018 to April 2019 the trust’s monthly median total time in A&E for all patients was lower than the England average in eight of the 12 months.

In March 2019, the trust’s monthly median total time in A&E for all patients was 167 minutes compared to the England average of 160 minutes. By August 2019 this had improved to 149 minutes against the England average of 157 minutes.

Median total time in A&E per patient - James Paget University Hospitals NHS Foundation Trust

Managers and staff worked to make sure that they started discharge planning as early as possible. We saw this in patient notes, at the ward board meetings and the operational board meeting we attended.
Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff liaised with discharge coordinators, ambulance services, patients GPs and the integrated care hub to ensure that appropriate patient care was provided for discharge.

Staff supported patients when they were referred or transferred between services. Staff escorted patients being transferred to other areas and there were clear handover procedures at patient bedside.

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 we spoke with knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters and leaflets available in all areas explaining how to complain.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were aware of the complaints process and would initially try to address any concerns before referring to the Patient Advice and liaison Service (PALS).

Managers investigated complaints and identified themes and we saw evidence of this in the complaint information we reviewed.

From June 2018 to May 2019 the trust received 42 complaints in relation to urgent and emergency care (18.8% of total complaints received by the trust). The main subject of complaints was all aspects of clinical treatment (23).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>23</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>5</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>5</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

For the 18 complaints that had been closed at the time of data submission, the trust took an average of 85.2 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 60 working days.

The 24 complaints that had not yet been closed had been open for an average of 70.0 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
We spoke with staff regarding the failure to investigate and close complaints within the 60 working days in line with the complaints policy. Staff commented that this was usually because the complaints involved multiple departments and that they felt it was better to have all information available for investigation before closing rather than reopening complaints.

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 heard about the shared learning from a complaint from a bereaved relative regarding the lack of information and support provided and all staff we spoke with were aware of the learning.

Complaints were discussed during directorate governance meetings. Both formal complaints and any informal concerns raised to the patient advise and liaison service. General themes were discussed as well as how many were complaint responses were outstanding.

**Number of compliments made to the trust**

From May 2018 to April 2019 there were 111 compliments received for urgent and emergency care (14.4% of all received trust wide).

Compliments were received in all 12 months of this period. December 2018 was the month where the most compliments were received (18).

The trust did not provide a breakdown by subject for compliments received.

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, 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 service was part of the Division of Medicine Clinical Support Services and Diagnostics led by a triumvirate of a clinical director, head of emergency care, and a speciality operational manager. All senior leaders were able to articulate their understanding of the challenges to quality and sustainability of the department. They had identified the actions required to address them.

Effective leadership was a clear priority and all senior managers told us about their leadership strategy. The urgent and emergency department had seen a significant boost to senior nursing with a designated senior nurse to lead the nursing workforce supporting additional band 7 senior sisters and band six nurses. This meant they were able to provide a manager of the day for seven days week with a band six coordinator 24hrs a day.
Staff felt that the ‘head of emergency care role’ had strengthened the management across urgent and emergency services. The dedicated band six role within the paediatric service had enhanced service development and clinical governance, supported by the head of children and young people service and the senior nurse in the emergency department (ED).

It was obvious from the way that staff interacted with each other that the senior leadership was visible and approachable. We saw senior managers working within the department at times of high patient demand and pressure.

Staff reported that all senior medical and nursing staff were approachable and available.

Vision and strategy

The service had a vision for what it wanted to achieve but no formalised strategy to turn it into action, developed with all relevant stakeholders. The service vision for developing the ED was 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 no formalised strategy for the service but there was a clear set of values, with quality and sustainability as the department’s top priorities. The service had a transformation/development plan to enlarge and reconfigure the ED service and was in the process of organising funding for the project. The service held regular meetings to monitor progress against delivery of the transformation plan and we saw evidence of this in the transformation meeting minutes.

Staff we spoke with knew and understood the trust vision, values and strategy, and their role in achieving them. The vision was ‘to be an innovative organisation delivering compassionate and safe patient care through a well-led and motivated workforce’. The values were ‘to put patients first; aim to get it right; recognise that everybody counts; and do everything openly and honestly’.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The culture within the urgent and emergency service was open and inclusive. Staff we spoke with said they felt valued and respected by their colleagues and leaders. We asked staff at all levels about the morale of the department and they said that morale was good and they worked well as a team.

There was a desire from all staff we spoke with to provide effective care and treatment to patients. We observed staff working well together and there were positive working relationships with the multidisciplinary teams.

We saw evidence of senior staff e-mailing the teams to share and praise good feedback and positive friends and family test (FFT) results.

The service promoted equality and diversity in daily work, and provided opportunities for career development. Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff. We spoke with two assistant practitioner staff who felt very positive regarding career development having been seconded to complete their qualifications.

The service had an open culture where patients, their families and staff could raise concerns without fear. The emergency department held group debriefs following incidents that
were likely to have affected staff emotionally, and had an “open door” approach to accessing support from the senior nursing and medical staff for those who felt affected by any event at work. Senior staff offered ‘Have your voice heard’ drop in sessions and the department had also set up a ‘Tea and Empathy’ service for junior doctors which became a trust-wide initiative.

Complaints and concerns were openly discussed with a ‘no blame’ culture and used as areas to learn from.

The hospital chaplains were well regarded and provided support to patients, relatives and staff when appropriate. The trust also held Schwartz rounds which were another way of helping to provide emotional support for staff following traumatic events. Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

Although there appeared to be a strong emphasis on the safety and well-being of staff we did hear from some staff that they often felt unnerved when working in the meet and greet room in the main waiting area late at night. This room did not have a panic alarm and although staff were issued with a personal alarm when working in the room some staff still felt at risk. We asked for any examples of when an incident occurred and were told of an incident when a GP had been working in the room next door and had been cornered by an aggressive patient. This had been reported as an incident and the personal panic alarms issued as a result and the furniture in the rooms reconfigured to reduce the risk of this occurring again. We raised staff concerns with the senior leadership team who were not aware that staff still felt vulnerable and confirmed that they would speak to staff who work in the room and look at reviewing the current arrangements.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There was a clear governance structure with regular bi monthly governance meetings.

The governance meeting’s agenda included regular items for example; clinical outcomes/effectiveness, mortality, patient safety, patient experience and clinical risk management. We reviewed meeting minutes from the ED for March, May and July 2019 and from the emergency admissions and discharge unit (EADU) and the ambulatory unit (AmBU) from April, June and August 2019 which demonstrated that the team worked together effectively monitored key performance indicators to improve performance and measure quality. Key messages from these meetings were cascaded to staff using various communication channels, such as email, notices and handover.

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. All staff we spoke with were clear about their roles and understood what they were accountable for, and to whom.

The service had arrangements with partners and third-party providers in place which were governed and managed effectively and encouraged appropriate interaction to promote coordinated, person-centred care. For example; Ambulance Liaison Quality & Safety Meetings with the local ambulance service provider, Quality & Safety Meetings with the local constabulary,
and the High Intensity User group included members of the local; clinical commissioning group, constabulary, council and community healthcare service.

**Management of risk, issues and performance**

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

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The service had up to date risks on the corporate trust risk register which used the red, amber, green (RAG) system to denote the level of risk and progress in resolving the risks.

Departmental risk was a regular agenda item on the departmental governance meeting agenda. However, although departmental staff could access risks to view they had no ownership of urgent and emergency care risks on the register, with local leaders having to go through the governance team to update or resolve risks. Senior staff did not feel that this delayed risk additions or updating although acknowledged that it would be easier if they were able to do so without the current process.

Potential risks were taken into account when planning services, for example, seasonal or other expected or unexpected fluctuations in demand to the department, or disruption to staffing or facilities. We saw this in the planned introduction of 24 hour security staff to the ED and the ability to schedule extra medical staff on night duty.

There were processes to manage current and future performance and we saw this in the regular performance meetings and reports, for example the Quality and Safety meetings and the Emergency Department Improvement Plan which was reviewed monthly to support both national performance and quality standards.

The service had a clinical and internal audit programme to monitor quality, operational and financial processes, and systems to identify where action should be taken. Audit data was reviewed in the governance meetings and we saw that there were plans to re-audit as appropriate.

The department had a full capacity protocol, there had been no reported instances of it being repeatedly used and there were no incidents of the ED being closed during the period from October 2018 to September 2019.

**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.

All staff completed information governance training as part of their trust induction.

There were computer stations throughout the urgent and emergency areas with access to the trust intranet and secure password protected access to patient data.

Staff told us there were enough computers for them to access information when they needed it. However, ED nursing staff we spoke with said that they did not have computer access to the wider electronic patient notes system, only the ED system. This meant that they were unable to see if a patient had recently had any non-emergency treatment, for example; planned surgery or
chemotherapy treatment that might have an impact on their emergency attendance. The medical staff did have access and nursing staff would ask medical staff to check if they had any concerns. Staff confirmed that there had been no incidents related to this process.

Staff had access to policies and standard operating procedures through the intranet. Staff we spoke with confirmed that this ensured information was easily accessible and up to date.

Data or notifications were consistently submitted to external organisations as required. For example; the Trauma Audit & Research Network (TARN), NHS Digital and NHS England quality indicators.

**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.**

Throughout our inspection, staff were welcoming and willing to speak with us. All staff we spoke with were proud of the department and the hospital. Staff were committed to improving and developing services.

The service held ‘Drop in And Learn’ teaching sessions on basic life support in public areas of the hospital which were open to staff and the public to attend.

The service held regular ‘away days’ instead of monthly staff meetings. The away days were scheduled and repeated which ensured that all staff had the opportunity to attend. We reviewed the agendas and attendance and saw that they were comprehensive and pertinent to the department and well attended by staff from all areas and grades.

Staff felt communication within the department and generally within the trust was good. Several different methods of communication were used including; a trust wide weekly e-bulletin to staff, departmental bulletins, staff emails, posters and information passed to them during handover. The ED had a monthly newsletter the’ Emergency Department Bulletin’ and the EADU and the AmBU had their own three monthly ‘Hot Topics’ newsletter which listed recent incidents, staff movement recent complaints, performance and articles of note to inform staff.

Success was celebrated with trust (remarkable people) awards. We heard about an ED inspirational leader winning an award in 2018 and local departmental employee of the month nominated by staff.

The service leads told us about various social and team building events at Christmas and Easter where staff dressed up and won prizes and of an ‘emergency snack box’ that the senior leads kept stocked with snacks to give staff a boost.

**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 EADU had introduced personal welcome packs including earplugs and eyeshades for patients and provided purpose designed named card envelopes for dentures and another envelope for
glasses/hearing aids for transport to other wards. The welcome packs were designed following some research by ward based staff.

The ED had introduced various supporting roles including physicians associates to provide support to the medical workforce with dedicated ED consultant support.

The electronic ward board flow system in the operation centre was particularly innovative providing ‘live’ updates to patient flow around the hospital. There were additional screens showing the ED dashboard, discharge lounge and ambulance situation. This ensured that department staff had oversight of bed movement throughout the hospital to facilitate patient flow out of the department. We attended a multidisciplinary lunchtime bed site meeting and saw that the meeting was well attended by the multidisciplinary team and included representation from the operations team, and the integrated care team. The meeting was well planned around the board and led by a bed site manager.

The department had a new award winning (recognised nationally via an architect’s design nomination) ambulatory care unit (AmBU) opened in 2018. The unit was designed with the clinicians and provided a dedicated one stop shop supporting patients to receive timely assessment and treatment in one place provided by a multidisciplinary workforce.

The ED had introduced Favorable Event Reporting Forms (FERF) to identify positive practice and the individuals involved. A multidisciplinary team reviewed the forms monthly and the learning points for each of the events identified. The learning points were then fed back both to the individuals involved, and to the rest of the team. The individual received a letter from the clinical leads of the team and the event and learning point were summarised and displayed on a noticeboard for staff, patients and visitors to see. The FERF initiative as well as enabling learning from positive practice, provides a mechanism for individual professional development and has increased morale among the multidisciplinary team.

Following feedback from staff and patients following the Hello my name is…… initiative.

The EADU has piloted staff photographs of the named nurse looking after the bay of patients supporting staff and carers to know who was the named nurse for the bay/side room. This received positive patient/staff/carer feedback and a trust rollout was planned for other inpatient areas.

The Emergency Department has initiated the ‘Hello my name is …… Boards’ within the cubicles to support patients/staff and carers.

To support continuing education for junior staff the department offered two hours per week of protected teaching time to middle grade doctors.

The ED had an active medical staff education social media group for sharing educational resources that they encountered online. Staff commented that this engendered a lot of healthy discussion and changes of practice where appropriate.

### Surgery

#### Facts and data about this service

The James Paget Hospital surgical services are provided to patients in Norfolk, Suffolk, Great Yarmouth and Waveney. The range of services on offer for patients include: elective and emergency care for trauma and orthopaedics, colorectal, upper gastro-intestinal, urology and
The service has seven theatres within the main theatre suite, four with laminar flow. Day surgery had three theatres all with ultra clean ventilation and an ophthalmic theatre with ultra clean ventilation.

The service is provided across a purpose-built day surgery unit and inpatient wards. The day surgery unit has 20 trolleys and is able to accommodate bariatric surgery. There are two general surgical wards with a total of 56 beds and a trauma and an elective orthopaedic ward totalling 50 beds. The trust also has an eight bedded private patient suite.

(Source: Acute Routine Provider Information Request – Context acute tab)

The trust had 24,829 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 4,241 (17.1%), 18,421 (74.2%) were day case, and the remaining 2,167 (8.7%) were elective.

(Source: Hospital Episode Statistics)

Our inspection of The James Paget Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust.

During the inspection we spoke with 29 members of staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We spoke with 12 patients and their relatives, reviewed 10 patient records and considered other pieces of information and evidence to come to our judgement and ratings.

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

Mandatory training completion rates

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training programme included a diverse subject range for staff to enable them to provide safe quality care to patients. Staff we spoke with told us that mandatory training programme met their needs.

Nursing staff received and kept up-to-date with their mandatory training. The combined mandatory training completion rate for nursing staff in surgery from May 2018 to April 2019 was 93.4%. Although the completion rate for two modules was below the trust’s target completion
rate. All of the nursing staff we spoke with told us they were up-to-date with mandatory training.

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

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention (level 2)</td>
<td>152</td>
<td>152</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety for managers</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>145</td>
<td>146</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>146</td>
<td>152</td>
<td>96.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>144</td>
<td>152</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>142</td>
<td>152</td>
<td>93.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>141</td>
<td>152</td>
<td>92.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>141</td>
<td>152</td>
<td>92.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>140</td>
<td>152</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>73</td>
<td>80</td>
<td>91.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>138</td>
<td>152</td>
<td>90.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>137</td>
<td>152</td>
<td>90.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>131</td>
<td>148</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical gases</td>
<td>126</td>
<td>147</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the trust had an overall mandatory training compliance rate of 93.0% for qualified nursing staff. The 90% target was met for 12 of the 14 mandatory training modules for which qualified nursing staff were eligible, and almost met for a one further training module.

Medical staff received and kept up-to-date with their mandatory training. The combined mandatory training completion rate for medical staff in surgery from May 2018 to April 2019 was 91.9%. Although the completion rate for four modules was below the trust’s target completion rate. All of the medical staff we spoke with told us they were up-to-date with mandatory training.

The divisional leadership team told us that they had organised mandatory training for medical staff within the trust induction and local induction programme to correctly capture the completion of the required training.

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety for managers</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>120</td>
<td>124</td>
<td>96.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>119</td>
<td>124</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In surgery the trust had an overall mandatory training compliance rate of 90.5% for medical staff. The 90% target was met for six of the 10 mandatory training modules for which medical staff were eligible.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The trust’s mandatory training programme included modules related to dementia, learning disabilities and autism. The mandatory safeguarding training also included Mental Capacity Act and deprivation of liberty safeguards training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers we spoke with told us they reviewed mandatory training completion dates when the off duty was completed, and they booked face-to-face training for staff or alerted staff if they were required to complete e-learning modules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff had completed all safeguarding modules and exceeded the trust target completion rate.

Safeguarding training included recognition, recording and reporting of female genital mutilation (FGM) for all staff, and further bespoke training was offered to departments who might identify FGM on a more regular basis, such as the gynaecology service. Staff we spoke with were knowledgeable about FGM and sexual exploitation, staff from the day care ward we spoke with, had completed the additional training regarding FGM. The trust had weekly grand round clinical case meetings which were attended by the safeguarding named nurses and named doctors and the safeguarding leads This provided a forum for additional case discussions and peer review of raised safeguarding concerns as required.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.
The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for qualified nursing staff in surgery is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>151</td>
<td>152</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>146</td>
<td>147</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>143</td>
<td>147</td>
<td>97.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – 3 Yearly</td>
<td>140</td>
<td>147</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>143</td>
<td>152</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>135</td>
<td>146</td>
<td>92.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery the trust had an overall safeguarding training compliance rate of 96.3% for qualified nursing staff. The 90% target was met for all six safeguarding training modules for which qualified nursing staff were eligible.

Most medical staff received training specific for their role on how to recognise and report abuse. Medical staff had completed safeguarding children to level one and two, in line with the trust’s target. Although the completion of safeguarding adult’s modules was just below the trust’s target of 90%. The safeguarding children level three training completion rate was very low compared to the trust’s target completion rate. The divisional leadership team had measures in place to address the completion of safeguarding training. They had identified that medical staff found attendance of mandatory training difficult, face-to-face training was delivered as part of junior doctor supervision and learning sessions.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>116</td>
<td>125</td>
<td>92.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>115</td>
<td>124</td>
<td>92.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>104</td>
<td>125</td>
<td>83.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>102</td>
<td>124</td>
<td>82.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>96</td>
<td>120</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – Annual</td>
<td>86</td>
<td>124</td>
<td>69.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the trust had an overall safeguarding training compliance rate of 83.4% for medical staff. The 90% target was met for two of the six safeguarding training modules for which medical staff were eligible.
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 identify patients at risk of emotional and physical harm. Staff gave examples of the types of situations where they had raised concerns. For example, a member of staff told us, they observed a patient’s changes in behaviour when a particular member of the patient’s family was present. The staff member raised concerns about the coercive nature of interactions with the patient.

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 knew the protected characteristics under the Equality Act and could explain actions they would take to protect patients from harassment and discrimination. Staff from the day care unit gave us examples of how they made adjustments for patients with complex needs, such as patients listening to music during their transfer to theatre to reduce anxiety.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated the process they used when they made a safeguarding referral and also told us the trust’s safeguarding team were approachable and supportive when they asked for help.

The safeguarding team was led jointly by the adult safeguarding lead and the children’s safeguarding lead, which ensured staff considered the needs of whole family units when raising concerns and supporting families. The safeguarding team had a visible presence throughout the trust and supported staff with mental capacity assessments, deprivation of liberty safeguarding applications and general safeguarding advice.

Surgery services made 11 safeguarding referrals to the local authority safeguarding board from June 2018 to May 2019. All of these referrals were reviewed by the trust’s safeguarding team for oversight. The trust had no adult or child serious case reviews in the 12 months prior to our inspection.

Staff had access to safeguarding policy documents on the trust’s intranet. We reviewed the safeguarding adults policy and the safeguarding children’s policy, we found these set out the roles and responsibilities of staff and the types of abuse. The policy documents were within the review date and referenced legislation and national guidance.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. 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 well-maintained. All areas we visited were visibly clean and free from clutter. We saw disposable curtains in used within ward bays with dates displayed when they were changed. On the wards each bay and side room had hand washing facilities for staff, patients and visitors to use. There were hand decontamination gel dispensers at ward entrances in corridors and at hand washing sinks.
Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records we reviewed showed that cleaning had taken place in ward areas and theatres. The matrons completed rounds to review environmental cleanliness and dealt with any issues identified at the time of the round.

Staff followed infection control principles including the use of personal protective equipment (PPE). In all areas we visited, staff decontaminated their hands appropriately before and after patient care. Staff wore uniforms with short sleeves and were bare below the elbows. They used personal protective equipment in line with the trust’s standard precautions policy and disposed of the items correctly.

Theatre staff wore theatre uniforms and used masks and hats, staff disposed of these appropriately after use to prevent the spread of hospital associated infections.

All wards we visited completed monthly hand hygiene audits to monitor staff compliance with infection prevention and control measures. The results showed that ward 22 and ward four achieved 100% consistently from September 2018 to August 2019. Ward 5 scored 100% except for June and August 2019 where staff missed opportunities to decontaminate their hands. Ward six scored 100% except for December 2018, March 2019 and June 2019 where staff also missed opportunities to decontaminate their hands. The trust did not provide a target to achieve for these audits. Managers identified issues with students that were not practicing the standard of hand hygiene expected by the trust, senior managers escalated this issue to the local universities to ensure all students had further hand hygiene education.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed reusable medical equipment such as dressing trolleys, intravenous infusion stands, and commodes were visibly clean and had dated green “I am clean” stickers attached to signify that the equipment had been cleaned and was ready for use.

The trust had an accredited sterile services department for the decontamination and sterilisation of reusable equipment for invasive procedures. Theatres had robust measures in place to separate sterile and dirty equipment. Staff checked equipment sets after each procedure to ensure the set was complete before being sent for decontamination. There was a full tracking and traceability process in place. Theatres tracked instrument sets used for a procedure electronically within the patient theatre record, this allowed traceability of sets or implants in the event of a recall or safety alert.

Theatres had systems in place for sterilising endoscopes in line with national guidance. An endoscope is an illuminated optical, typically slender and tubular instrument used to look deep into the body. We reviewed rigid endoscopes and saw these were vacuum packed with a sticker containing tracking and tractability data.

Staff worked effectively to prevent, identify and treat surgical site infections. The service had identified three surgical site infections from September 2018 to August 2019. The service was compliant with the surgical site infection reporting for orthopaedic surgeries, such as total knee replacements and total hip replacements. We saw that the trust reported orthopaedic surgical site infections to Public Health England in line with mandatory reporting requirements.
Surgical patients were screened for hospital associated infections such as methicillin resistant staphylococcus aureus (MRSA) and Clostridium Difficile (C-Diff). Elective surgical patients received screening during their pre-assessment appointment prior to their admission to hospital. All patient with positive results were followed up by the infection control team and were not admitted for surgery until they had three negative results. Patients on the emergency surgical pathway of care were screened during the admission process and isolated appropriately if there were any concerns about hospital associated infections.

The trust had processes in place to ensure separation of elective surgical patients from emergency surgical patients before and after surgery to reduce the risk of the spread of healthcare associated infections.

**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. Each bed space on the wards had a call bell system. We observed call bells were within the reach of patients, and when patients called for help, staff were prompt responding to their needs. Patients we spoke with told us staff answered their call bell in a timely way.

The design of the environment followed national guidance. The day surgery unit had 20 trolleys and was able to accommodate bariatric surgery. Day surgery had four theatres all with laminar flow. The main theatre suite had seven theatres, three theatres had laminar flow. Surgery had four wards, two wards for general surgical wards with a total of 56 beds, and two wards designated trauma and an elective orthopaedic ward totalling 50 beds.

Staff carried out daily safety checks of specialist equipment. Ward staff completed daily checks of the emergency resuscitation trolleys. We reviewed records on the day care unit and ward four which showed these checks had taken place without any gaps for July, August and September 2019.

Theatres had processes to check equipment such as anaesthetic machines and the malignant hypertension trolley in place (which contained equipment and medicine to counteract a severe reaction to an anaesthetic). Records we reviewed showed staff had completed daily checks for these items.

The estates department managed equipment such as blood pressure machines and intravenous infusion pumps. They were responsible for servicing and maintenance of equipment in line with the manufacturer’s recommendations and national guidance. The estates department distributed a schedule detailing equipment replacement every six months to the division managers.

The service had enough suitable equipment to help them to safely care for patients. The service used a range of single use consumable equipment items such as syringes, needles and intravenous infusion lines. We randomly checked 43 items of single use equipment and found they were stored appropriately and were within their expiry date.
Staff disposed of clinical waste safely. We saw that waste bins were monitored throughout the day and staff disposed of clinical and domestic waste appropriately. Staff disposed of sharp items, such as injection needles, in clinical waste sharps bins. We reviewed five sharps bins and found these were labelled, dated, included the clinical area and were not overfilled.

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. Staff used the NEWS2 tool to monitor patients and identify a deteriorating patient. NEWS2 is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient vital observations. We reviewed 10 NEWS2 charts and found they were completed correctly and escalated appropriately.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Staff completed risk assessments such as the Waterlow pressure ulcer risk, malnutrition universal scoring tool and fall risk assessments as part of the patient admission process. Staff reviewed these risk assessments daily and updated the assessments as the patient’s condition changed. We reviewed 10 patient records and found that all of the patient records had completed risk assessments. The surgical division completed an audit of completion of NEWS2 patient observations and escalation in December 2018. The division reviewed 58 case records and found that staff compliance was 89.65% against the measures of theory and practice combined. Surgery completed a further NEWS2 audit in April 2019 which demonstrated an improvement where compliance increased to 95% against theory and practice elements.

Staff knew about and dealt with any specific risk issues. Staff we spoke with knew how to escalate a deteriorating patient and had access to support from the critical care outreach team when required. Staff told us they used the sepsis six care bundle, sepsis six is the name given to a bundle of observations to indicate sepsis and treatments designed to reduce mortality in patients diagnosed with sepsis.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Mental health support was provided by a local mental health NHS trust which provided a psychiatric liaison service from 7am to midnight, every day. Staff had access to the crisis response service outside of these hours provided by a local mental health NHS trust.

Staff shared key information to keep patients safe when handing over their care to others. Staff used the SBAR (situation, background, assessment and recommendation) handover tool. The tool was used for routine handovers, such as shift changes and receiving patients from theatres to the ward. Staff also used the tool to escalate deteriorating patients to medical staff.

Shift changes and handovers included all necessary key information to keep patients safe. Each ward held multidisciplinary team board rounds every morning. Staff discussed any changes or concerns related to a patient’s condition such as deterioration in clinical observations and if
escalation had taken place. The team completed face-to-face reviews with patients following the board rounds.

Theatres used the World Health Organisation (WHO) five steps to safer surgery checklist both in main theatres, day surgery theatres and the ophthalmology theatre. Staff used an electronic system to audit compliance, with briefing, sign in, time out, sign out and debrief stages of the World Health Organisation (WHO) five steps to safer surgery checklist in main theatres. The theatre manager monitored the audit for all theatre cases. However, we found that the theatres did not capture or audit the details of the debrief element of the checklist other than through the peer review of the process once a month. This meant that department missed opportunities for wider staff learning. We spoke with the theatre manager during our further unannounced inspection, who told us they had identified issues with way captured debrief discussions, prior to our inspection. In response the theatre team had redesigned the briefing and debriefing sections, we saw that the draft version had a briefing and debrief section for notes to capture learning. The draft had been sent to anaesthetists for consultation and the manager planned for document to be reviewed by the next divisional governance meeting for sign off.

Divisional managers and theatre leadership team we spoke with told us that main theatres and day surgery completed a monthly World Health Organisation (WHO) and five steps to safer surgery checklist peer review audit. This was completed for one procedure in each theatre and by a member of another theatre team. The completion of World Health Organisation (WHO) and five steps to safer surgery checklist was monitored through the electronic system for all procedures.

We reviewed the World Health Organisation five steps to surgical safety audits from September 2018 to August 2019, which showed that staff compliance was from 99.5 to 100% consistently. The theatre manager told us they followed up any inconsistencies with the theatre team if one element was found to be incomplete.

Theatres had a major haemorrhage protocol in place. A copy of the protocol was available in each theatre for staff to follow in the event of major haemorrhage protocol was triggered. The events of the major haemorrhage were discussed during the team debrief following the incident with all team members. All major haemorrhage protocol incidents were reported and reviewed after the event for learning and improvement.

Main theatres, ophthalmic theatres and the day surgery unit kept a device and implant register for traceability of use. Details of devices and implants were included within a patient’s record which recorded the device or implant and the serial number for traceability.

The trust had a major incident plan and a business continuity plan in place. Both documents set out staff roles and responsibilities in the event of a major incident internally or externally to the trust. Both documents were updated on a regular basis and had a version control. The trust had used the business continuity plan successfully prior to our inspection due to issues identified with the diagnostic imaging system. Staff told us processes that put in place to manage safe patient care and treatment where images of surgical patients could not be viewed.

Surgery had developed Local Safety Standards for Invasive Procedures (LocSSIPs) following the introduction of National Safety Standards for Invasive Procedures (NatSSIPs). The LocSSIPs and NatSSIPs were in place to prevent surgical never events. An example of a local safety standard was, stop before you block, the service developed this protocol following a never event, where an anaesthetic block was completed on the wrong side of a patient’s body.
Surgery had staff with additional training to monitor and provide treatment to deteriorating patients. The service had staff with up-to-date intermediate life support training in addition to basic life support training. Information provided by the trust showed that 11 staff members across ward 5, ward 6 and ward 22 had this additional training.

**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. All of the wards we visited were staffed to their planned establishment. The ward manager on ward six told us that the ward was over established which allowed for cover for maternity leave.

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. Surgery was fully aligned to the recommendations outlined in the national Quality Board Improvement Resources and NICE guidance for staffing assessments. Surgical services were included in the trust’s annual staffing review, staff reviewed staffing in line with Royal College of Nursing (RCN) guidance and used the Shelford acuity tool to monitor daily staffing needs. Staffing for each ward was reviewed daily, if there were staffing shortages a risk assessment was performed and staff were moved where appropriate to mitigate any staffing risks identified.

Theatre staffing levels were in line with the association for peri-operative practice guidance. The theatre manager told us that consultants requested extra staff for larger surgical theatre cases, these were planned in advance which ensured the availability of further staff. Staffing rotas were planned in accordance with staff competencies, which meant all staff had the necessary skills and training for each planned theatre list.

There was an emergency out of hours on call theatre team in addition to the planned 24 hour theatre list cover. This team were called when a second theatre team was required for further emergency cases.

The ward manager could adjust staffing levels daily according to the needs of patients. Ward staffing levels were monitored in real time at a daily staffing summit. The director of nursing (or deputy director of nursing) ensured actions were in place when required to reduce the impact of risk and other safe staffing concerns. Staffing actions regarding safe staffing were managed within the surgical division during core hours and via the central operations centre out of hours.

The number of nurses on all shifts on each ward matched the planned numbers. Data provided by the trust following our inspection showed that surgery was over established during August 2019. The planned nursing hours for the service was 11,422, the actual hours worked by registered nurses was 11,652.

**Trust level**
The table below shows a summary of the nursing staffing metrics within surgery at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.

<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>616</td>
<td>9%</td>
<td>8%</td>
<td>4.9%</td>
<td>7,722 (3%)</td>
<td>15,095 (6%)</td>
<td>7,762 (3%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>140</td>
<td>3%</td>
<td>6%</td>
<td>4.0%</td>
<td>7,722 (3%)</td>
<td>15,095 (6%)</td>
<td>7,762 (3%)</td>
</tr>
</tbody>
</table>

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

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

The service had an annual turnover rate of 6% for registered nurses. Managers we spoke with told us that the turnover rate was affected by staff retiring and some younger members of staff had left to work within a local regional centre for their career progression.

The senior management team had identified the challenge in their operational plan of attracting staff to work within the trust due being a smaller hospital than a neighbouring trust. The trust had developed a junior and senior health academy, the concept was to encourage young people into a career in the NHS and provide them with life skills. The health academy had pathways into the university degree programmes such as the nursing apprenticeship scheme. Staffing was included on the board assurance risk register.

The service had a proactive approach to the development of the nursing workforce. The trust actively participated in the nursing apprenticeship scheme in conjunction with local universities to provide nursing training to degree level. Ward managers we spoke with had apprentice nurses and trainee nursing associates within their wards. Both of these trainees had opportunities to become registered nurses subject to passing practice and theory elements of their training programme.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The day care ward manager told us the ward did not use agency or bank staff, ward staff worked extra shifts or swapped their days off to cover any rota gaps. Other surgical ward managers we spoke with used bank and agency staff to fill any gaps when required. Ward managers said they used bank and agency staff for enhanced one to one observation when they
had patients with complex needs such as dementia.

**Vacancy rates**

Each ward had vacancy rates at or below the trust target. The information provided by the trust prior to our inspection showed the service had low vacancy rate. The chart below demonstrates the low vacancy rate in surgery.

![Vacancy rate chart](image)

Monthly vacancy rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

**Sickness rates**

The service had increased sickness rates. We spoke with ward managers about staff sickness, they told us, members of staff were off with long term sickness, where staff had chronic illnesses or sustained injuries outside of work. Ward managers told us they managed sickness in line with the trust’s sickness policy. The senior leadership team for the trust had identified the increase in staff sickness rates across the trust and had developed initiatives to support staff to stay at work. These initiatives were focused on stress related staff sickness such as tea and empathy, where staff offered their time to support other members of staff.
Monthly sickness rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed an upward trend from October 2018 to March 2019.

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

**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 locum staff a full induction.

The service had enough medical staff to keep patients safe. Although the service had high vacancy rates for medical staff, managers ensured there were enough medical staff to safely care for patients at all times. Managers booked locum doctors to fill vacant shifts for medical staff. The information provided by the trust shows there were no unfilled medical staffing shifts from May 2018 to April 2019.

**Trust level**

The medical staff matched the planned number on all shifts in each department. The table below shows an over establishment of hours covered by medical staff.

The table below shows a summary of the medical staffing metrics within surgery at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.

<table>
<thead>
<tr>
<th>Surgery annual staffing metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2018 – April 2019</td>
</tr>
<tr>
<td>Staff Group</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Target</td>
</tr>
<tr>
<td>All staff</td>
</tr>
<tr>
<td>Medical staff</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

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

Please note that the negative unfilled hours in the table above are due to the trust over-recruiting at a junior level to assist with the safe management of gaps to meet service demand. This is on a fixed term contract for 12 months. This supported the rota and avoided the use of agencies.

The service had high turnover rates for medical staff. The divisional leadership team reported that they faced challenges with the attraction and retention of medical staff due to the geographical area and the attraction of working at a regional hospital nearby. The division had an ongoing recruitment drive in place, the leadership team planned to identify appropriate roles that could be filled with advanced nurse practitioners and advance care practitioners to address the issue with recruitment of medical staff. The leadership team wanted to emulate trusts that have already developed these types of roles.

The service had high rates of bank and locum staff used on the wards. Prior to our inspection the trust provided information that locum doctors were used to fill vacant shifts. For example, the service used locum medical staff to reduce the patient referral to treatment times. The trust had ongoing recruitment initiatives in place to encourage medical staff to apply for vacant posts. The trust planned to employ associate consultants and provide development to future consultant roles.

Managers could access locums when they needed additional medical staff. The service filled medical staff vacancies with planned long-term locums in advance. Managers could also arrange locum staff for short notice cover.

Managers made sure locums had a full induction to the service before they started work. The trust had a locum induction programme in place. All locums had to complete an induction programme before they started working at the trust.

**Vacancy rates**

The service had high vacancy rates for medical staff. The senior management team had identified their challenges of attracting staff due to competing for staff with a larger NHS
Monthly vacancy rates from May 2018 to April 2019 for medical staff showed a shift from November 2018 to April 2019.

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

Surgery had appointed medical staff to associate consultant posts within anaesthetics and orthopaedics with a view to develop these staff members to consultant roles. Associate consultants are senior middle-grade doctors, these doctors usually worked independently and were attached to a consultant within their specialty.

The service was exploring ways of diversifying their workforce with advanced practitioner nurse leads within services such as endoscopy and ophthalmology.

**Sickness rates**

Sickness rates for medical staff were low. The chart below shows that the sickness rates for medical staff in surgery were consistently below the trust’s target of 4%.
Monthly sickness rates from May 2018 to April 2019 for medical staff showed a shift from November 2018 to April 2019.

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

Staffing skill mix
The service had a good skill mix of medical staff on each shift and reviewed this regularly. The skill mix of medical staff was broadly in line with the England average for each grade. Although the trust had an increased number of middle career doctors to fill registrar and junior doctor posts.

As of February 2019, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the whole-time equivalent staff working at James Paget University Hospitals NHS Foundation 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>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>15%</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
The service always had a consultant on call during evenings and weekends. The service had changed the on-call system. The service had moved to electronic job planning, this meant that consultants were on-call for a week in their speciality. The consultant on-call was assisted by the consultant on-call from the previous week who managed theatre cases. This new on call system also improved continuity of care to patients. Consultants we spoke with told us this system worked well and it enabled them to provide greater support to junior doctors.

**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 records were comprehensive, and all staff could access them easily. Staff used paper patient records to record patient care. Medical, nursing and therapies staff recorded care in the same record to ensure a complete and contemporaneous record of information to deliver safe patient care.

We reviewed 10 patient records from three clinical areas and we found that they were legible, signed and dated. All records contained pre-operative assessments either as part of a pre-admission assessment or as part of the emergency admission pathway. The records were contemporaneous and demonstrated an on-going plan of care and that intentional rounding had taken place. All the records we reviewed, had up to date risk assessments such as Waterlow pressure ulcer risk, malnutrition universal scoring tool (MUST) and a falls risk assessment.

Day surgery and main theatres used electronic patient records. We saw that a printed copy of the theatre care records was filed in the paper records before patients were transferred to a ward.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff ensured patients records were transferred with patients from one area to another within the hospital. Medical staff completed discharge summaries electronically which were sent directly to the patient’s GP through the electronic system. Staff printed a copy of the discharge summary, which was given to the patient.

Records were not stored securely. Patient records were stored in trolleys within staff areas of the ward. However, trolleys were not locked which meant records were accessible to those who did not have permission to access records. We spoke with ward managers who told us that the division had a risk assessment in place, senior staff assessed there was a higher risk of staff not being able to access the records in an emergency than records being accessed by a patient or visitor. We raised this as a concern with executive team during our inspection. Following our inspection, the trust managers completed a further risk assessment for the storage of patients records and informed us they had taken measures to ensure records were kept securely and matrons completed spot checks to monitor compliance. We followed up the concerns during the well-led inspection, where we found unsecured records trolleys on all of the wards we visited. Therefore, we were not assured that records were being stored securely.

**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. Patient prescription charts were computerised. All administered medicines were blocked out with a grey colour to reduce the risk of staff re-administering medicines or pain relief.

Most of the surgical wards used electronic prescription charts for all medicines except for intravenous fluids. The day care unit used paper prescription charts for all medicines prescribed and administered by staff.

We spoke with staff about the electronic prescribing system, they told us the system was useful as doctors could review medicines during the ward round or from another area of the hospital. Staff told us this meant it was quicker to get prescriptions such as additional pain-relieving medicines for their patients. One member of staff told us they could see if another member of staff was reviewing the prescription record during a drug round which would prompt them to find out if there were planned changes to the prescription chart before administering any medicines.

We observed that staff kept medicines fridges locked and monitored the temperatures daily. We reviewed the fridge temperature records on two wards and in theatres and found these were completed daily without gaps.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. The electronic prescribing system had notes for a reason why medicines were stopped, changed or added, which helped staff explain to their patients what the medicines were administered. Staff discussed medicines and provided advice to patients prior to their discharge, they explained when and how the medicines should be taken. This information was included in the discharge summary given to patients.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We saw medicines were stored in locked rooms or locked cupboards. Staff kept controlled drugs in wall mounted metal cupboards in line with legislation. We checked controlled drugs on two wards and in theatres and found that stock levels matched the records.

The trust had antibiotic prescribing guidance in place for staff to follow in the treatment of infections and sepsis. The guidance was within the review date and referenced national guidelines. The trust had a patient group directive (PGD) in place for registered nurses to administer antibiotic medicines when patients had triggered red flags for sepsis to enable timely antibiotic treatment. Nurses could only administer antibiotics follow training and competency sign off and when a junior doctor was unable to attend the ward within 30 minutes.

Records contained clear documentation where antibiotic therapy was indicated and provided information about the drug, dose and the duration.

Staff followed current national practice to check patients had the correct medicines. We observed staff administering medicines on the wards, they checked medicine prescription, allergies, dosage and patients’ wrist identity bands against the prescription chart before they gave patients their medicines.
The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff discussed key messages during their shift handovers, this included safety alerts and learning from medicines incidents. The electronic prescribing system also provided staff with safety alerts related to specific medicines.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed eight medicine charts (both paper and electronic) and saw no evidence of excessive or inappropriate use of medicines to control behaviour in patients with complex needs.

Staff in pre-assessment discussed pain management and medications with patients so they were prepared for their elective admission to hospital. Patients we spoke, told us they appreciated the opportunity to discussed medicines used for pain relief prior to their procedure.

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.

Staff knew what incidents to report and how to report them. Staff we spoke with knew how to report an incident or near miss. Staff gave examples of incidents they had reported such as, patient falls and incidents of violence and aggression from patients or their relatives. Staff demonstrated to us the electronic system they used to report incidents.

Staff reported all incidents that they should report. Staff we spoke with told us they reported incidents even if they were not sure if it was serious or required, to ensure there was a record of events. Managers told us, there was an open reporting process to encourage learning from incidents or near misses. The national reporting and learning system (NRLS) and strategic executive information system (StEIS) demonstrated that staff reported incidents appropriately.

Never Events

The service had no never events on any wards. The service had no never events in the 12 months prior to our inspection.

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 May 2018 to April 2019, the trust reported no incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))
Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. The service reported five serious incidents from May 2018 to April 2019. Staff told us about a further serious incident that had occurred in day surgery prior to our inspection. Staff knew about the incident and the actions they needed to take to prevent a similar incident in the future.

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

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

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips/trips/falls</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Managers debriefed and supported staff after any serious incident. Managers we spoke with told us they discussed incidents with the staff involved to provide support. Staff we spoke with, told us they felt supported by their managers during incident investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff and managers, we spoke with knew and understood their responsibilities in relation to the duty of candour.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed two root cause analysis investigation reports following serious incidents. The reports gave a factual timeline of the events and analysed patient records to highlight learning and areas for improvements in practice. Managers shared the reports with patients and the relatives and offered a face to face meeting with patients to discuss the incident and investigation findings.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with gave us examples of feedback following incidents. Staff spoke about the key messages shared at handovers and by emails, which included incidents that had happened in another area of the hospital. Staff we spoke with knew to ensure patient dentures were removed before their procedure, following an incident in day surgery ward.

Staff met to discuss the feedback and look at improvements to patient care. Ward managers discussed incidents during the divisional ward managers meetings, however managers did not keep minutes of these meetings. The divisional management team discussed incidents during the divisional governance meeting and the divisional board meetings. We reviewed the meeting...
minutes from April 2019 to July 2019 which demonstrated that managers discussed the trends and themes of incidents reported. We saw areas such as reporting trends on ward four were mainly for pressure ulcers and increased needle stick injuries across the division. The divisional managers had actions in place to reduce the incident of needle stick injuries.

The trust screened all unexpected deaths within the hospital. Since April 2019 a medical examiner reviewed any deaths identified and these were investigated using either the serious incident framework or a structured judgement review. Once the investigation was completed, learning was shared within mortality groups and grand rounds (specialist patient review meetings). Learning themes were reported to the board of directors, local governance forums and at team meetings.

There was evidence that changes had been made because of feedback. We observed changes to practice, patient’s partial denture plates were removed before surgical procedures following a serious incident in day surgery theatres. We also saw a pilot project on ward four to monitor lying and standing blood pressures during the patient’s admission assessment to help reduce the risk of falls.

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. Surgical wards displayed safety thermometer information at the ward entrance, except for the day care ward where patients did not stay overnight on the ward.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months. The information in the charts below demonstrates that the service achieved 95% 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 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 nine new pressure ulcers, one fall with harm and eight new catheter urinary tract infections from April 2018 to April 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at James Paget University Hospitals NHS Foundation Trust
Staff used the safety thermometer data to further improve services. Ward managers and staff used the safety thermometer information to make improvements to patient care and working practices to reduce patient harm. Ward six had introduced a quality improvement initiative called 'mission to reposition' to aid the reduction of service acquired pressure ulcers. The ward started this initiative in April 2019 and had not had a service acquired pressure ulcer since 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. 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 had access to policy and guideline documents on the trust’s intranet, we observed staff accessing them easily.

Staff provided care based on national guidance and best practice including but not limited to, the Royal College of Surgeons (RCS). We saw that elective and non-elective patients were assessed, and the service separated elective and emergency patients in line with the RCS standards for unscheduled surgical care and treatment.
All elective surgery patients had pre-operative assessments which followed a documented pathway, this ensured staff gathered all the relevant information and prepared patients for their surgery. This was in line with the Association of Anaesthetists and the British Association of Day Surgery guidance.

We reviewed a range of trust policies such as, but not limited to, the safeguarding adult’s policy and the consent policy. We saw that the policy documents we reviewed were within their review date, ratified and had version control. The documents referred to national guidance and legislation.

Staff accessed evidenced based tools to identify and treat patients with sepsis. The sepsis six tool was used in conjunction with the NEWS2 assessment tool to identify patients at risk of sepsis. Staff used the tools in line with the trust’s assessment and management of sepsis in adult’s guideline, which referred to national guidance and was within the review date.

Policy and pathway documents were inclusive of patients with disabilities and people with protected characteristics. Staff made appropriate adjustments for patients with complex needs and planned individualised care to meet these needs in line with trust policy, such as the consent to treatment.

The orthopaedic ward used a fractured neck of femur pathway, which fast tracked patients who had sustained a fractured neck of femur injury from the emergency department to one of the protected beds in surgery. This was in line with national institute for clinical excellence (NICE) guidance.

Theatres completed peer review audits for the quality of the World Health Organisation five steps to surgical safety. This audit was completed by a staff member from a different theatre team to where they worked, one list was audited for each theatre every month.

**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 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. Staff monitored patients’ nutrition and hydration needs. Patients had access to water at their bed side. Surgical wards had protected meal times, which meant staff prioritised these times to hand out hot meals and provide patients with assistance to eat their food if this was required.

Medical and ward staff worked with dieticians to manage patients with post-operative complications, for example, when bowel function was interrupted or obstructed, and intravenous total parental nutrition (TPN) was required.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 10 sets of patient records of these, five patients had fluid balance or food charts. Staff had completed the charts and we saw the fluid balance charts had been calculated correctly.
Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff identified patients who required a personalised individual nutritional plan through the malnutrition universal screening tool (MUST). Staff referred patients to dieticians if they required enhanced nutritional diets.

Specialist support from staff such as dieticians was available for patients who needed it. Pre-assessment staff and ward staff referred patients to dieticians to aid preparation for surgery or post operatively if there were any concerns about a patient’s nutritional needs, in particular, following upper and lower gastro-intestinal procedures. Staff we spoke with, told us that the process of referral was straight forward.

Staff offered patients medicines for the management of nausea and vomiting where appropriate. Staff we spoke with told us that anaesthetists prescribed medicines to manage nausea and vomiting either before a surgical procedure or before patients were transferred from recovery to the ward.

Patients waiting to have surgery were not left nil by mouth for long periods. Surgery had strict protocols in place for pre-operative fasting which followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance of no food six hours before the procedure and 30 millilitres of fluid every hour until the procedure. Staff we spoke with knew this protocol and followed it when caring for pre-operative patients.

**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. Staff asked patients about their pain during comfort rounds, taking vital observations and during drug rounds. Patients were asked to score the pain between one and 10, 10 represented the highest levels of pain. Pre-assessment staff discussed pain management with patients prior to their surgical procedure.

Patients received pain relief soon after requesting it. Patients we spoke with told us their pain had been managed well by staff and told us staff administered pain relieving medicines in a timely way, after they had reported they were experiencing pain.

Recovery staff we spoke with, told us they monitored patients’ pain levels and would not transfer patients back to ward until their pain was well managed.

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records we reviewed showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day and additional medicines for any break through pain. We observed that staff had administered pain relieving medicines to patients as they had been prescribed.

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

Managers carried out a comprehensive audit programme. The service had a programme of local and national audits in place to benchmark the service against other NHS trusts, local policy compliance and service improvements. Surgery services had participated in the ‘getting it right the first time’ (GIRFT) review for breast surgery. The service had action plan in place following this review to improve the service for breast surgery patients. The service had an action plan in place which there were actions aligned to staff to complete, with deadlines to complete each action.

Managers used information from the audits to improve care and treatment. We saw local quality improvement projects in three of the ward areas we visited, the ward managers compiled data monthly to measure the impact of the project on patient outcomes. For example, the mission to reposition pilot on ward six in the reduction of service acquired pressure ulcers. We saw that the ward had not reported a service acquired pressure ulcer since June 2019.

Managers shared and made sure staff understood information from the audits. We saw that managers displayed relevant audit results in staff areas. An example of this was the World Health Organisation five steps to surgical safety in theatres, all staff we spoke with understood the reason for the audit and the importance of compliance.

Ward staff received feedback about the hand washing audit results from their managers. Staff received one to one feedback about their practice if any issues were identified.

Improvement is checked and monitored. The divisional specialist teams monitored audit results and reported the results and any resulting improvement action plans to the divisional board.

Relative risk of readmission

The service had a lower than expected risk of readmission for elective care than the England average. The table below illustrates the trust performance for this measurement.

James Paget Hospital

From February 2018 to January 2019, patients at James Paget Hospital had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

The chart below shows the risk of readmission for the top three specialties, based on count of activity for elective admissions:

Elective Admissions - James Paget Hospital
General surgery, ophthalmology and trauma and orthopaedics patients at James Paget Hospital had lower than expected risks 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. The table below illustrates the trust performance, for this measurement.

**Non-Elective Admissions - James Paget Hospital**

General surgery, urology and trauma and orthopaedics patients at James Paget Hospital had lower than expected risks of readmission for non-elective admissions when compared to the England average.

*(Source: Hospital Episode Statistics)*

The service participated in all relevant national clinical audits. The service performed similar or better in comparison to other that in most measures of the national clinical outcome audits and managers use the results to improve services further. The trust participated in a variety of national audits. Senior managers we spoke with, told us that surgical specialities discussed the results within their team meetings and identified actions to improve patients’ outcomes.

**National Hip Fracture Database**

**James Paget University Hospital**

The table below summarises James Paget University 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.
### Metrics (Audit indicators)

<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><strong>Case ascertainment</strong> <em>(Proportion of eligible cases included in the audit)</em></td>
<td>106.9%</td>
<td>Better</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude proportion of patients having surgery on the day or day after admission</strong> <em>(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)</em></td>
<td>64.5%</td>
<td>Worse</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Crude peri-operative medical assessment rate</strong> <em>(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)</em></td>
<td>98.0%</td>
<td>Better</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Crude proportion of patients documented as not developing a pressure ulcer</strong> <em>(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)</em></td>
<td>95.8%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td><strong>Crude overall hospital length of stay</strong> <em>(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)</em></td>
<td>18.8 days</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td><strong>Risk-adjusted 30-day mortality rate</strong> <em>(Adjusted scores take into account the differences in the case-mix of patients treated)</em></td>
<td>6.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

*(Source: National Hip Fracture Database)*

The division had changed consultants on-call rotas and theatre scheduling processes which enabled consultants to manage emergency surgical cases more proactively and created flexibility in the theatre schedules. Senior managers told us the changes were in their infancy and were awaiting data to show an improvement in the admission to procedure waiting times.

### Bowel Cancer Audit

The table below summarises James Paget University Hospitals NHS Foundation 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></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Case ascertainment

(Proportion of eligible cases included in the audit)  

<table>
<thead>
<tr>
<th>Measure</th>
<th>Proportion</th>
<th>Result</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection</td>
<td>101.8%</td>
<td>Good (over 80%)</td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate</td>
<td>67.4%</td>
<td>Worse than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate</td>
<td>5.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate</td>
<td>7.7%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection</td>
<td>45.5%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit)

### National Vascular Registry

James Paget University Hospitals NHS Foundation did not participate in this audit.

(Source: National Vascular Registry)

The trust did not offer vascular surgery, all patients who required vascular surgery were referred to another NHS hospital in the area.

### 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.
Trust-level metrics
(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)

<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>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</td>
<td>17.1%</td>
<td>Similar</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk adjusted 90-day post-operative mortality rate (Proportion of patients who die within 90 days of their operation)</td>
<td>Not eligible</td>
<td>Not applicable</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

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.)

<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>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 performed better or similar to other trusts in this national audit.

National Emergency Laparotomy Audit

The table below summarises James Paget University Hospital’s performance in the December 2016 - November 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>65%</td>
<td>Amber</td>
<td>Not met</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>59%</td>
<td>Amber</td>
<td>Not met</td>
</tr>
<tr>
<td>Crude proportion of cases with access to theatres within clinically appropriate time</td>
<td>87%</td>
<td>Green</td>
<td>Met</td>
</tr>
</tbody>
</table>
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 and Anaesthetist present at the time of their operation)

82%  Amber  Not met

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)

84%  Amber  Not met

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)

16%  Worse than expected  No current standard

(Source: National Emergency Laparotomy Audit)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises James Paget University Hospitals NHS Foundation Trust's performance in the 2018 National Ophthalmology Database 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</td>
<td>77.1%</td>
<td>-</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted posterior capsule rupture rate</td>
<td>1.3% Within expected range</td>
<td>No current standard</td>
<td></td>
</tr>
<tr>
<td>Risk adjusted visual acuity loss</td>
<td>No data available</td>
<td>-</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Ophthalmology Database Audit)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)
The table below summarises James Paget University Hospital’s performance in the 2018 National Joint Registry.

<table>
<thead>
<tr>
<th>Trust-level</th>
<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></td>
<td>Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (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)</td>
<td>85.5%</td>
<td>Similar</td>
<td>Not met</td>
</tr>
<tr>
<td>Hospital level: Hips</td>
<td>Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who need their hip replacement ‘re-doing’)</td>
<td>0.7</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Hospital level: Knees</td>
<td>Risk-adjusted 5 year revision ratio (for knees excluding tumours) (Proportion of patients who need their knee replacement ‘re-doing’)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) (Proportion of patients who die within 90 days of their operation)</td>
<td>0.6</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) (Proportion of patients who die within 90 days of their operation)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: National Joint Registry)

National Prostate Cancer Audit

The table below summarises James Paget University Hospitals NHS Foundation 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>97.2%</td>
<td>N/A</td>
<td>Not met</td>
</tr>
<tr>
<td>Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy</td>
<td>No data available</td>
<td>-</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
(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)

<table>
<thead>
<tr>
<th>Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy (Complications following surgery may reflect the quality of surgical care)</th>
<th>No data available</th>
<th>-</th>
<th>No current standard</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>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)</th>
<th>No data available</th>
<th>-</th>
<th>No current standard</th>
</tr>
</thead>
</table>

(Source: National Prostate Cancer Audit)

The trust worked to improve services with the regional NHS centre within the local sustainability and transformation partnership (STP). Urology was one of the first specialities that moved to the one service, one waiting list initiative within the local STP to improve services and waiting times for patients. The senior managers for surgery had difficulties with the recruitment and retention of urology consultants, which was one of the main drivers for the partnership formed with the local NHS trust.

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.

The visual analogue scale (EQ VAS) asks patients to mark their 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 uses 5 levels of responsiveness to measure problems. The range is; no problem -
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 on groin hernias was worse than the England average for both indicators.

For hip replacements, performance was worse than the England average for EQ-VAS and similar to the England average for EQ-5D and Oxford Hip Score.

For knee replacements performance was better than the England average for EQ-VAS and similar to the England average for EQ-5D index and Oxford Knee Score.

For varicose veins, performance was worse than the England average for Aberdeen Varicose Vein Questionnaire and EQ-5D Index. For the Varicose Vein EQ VAS the trust was worse than the England average for those patients that reported an improvement but better than the England average for patients that reported feeling worse.

(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. Staff we spoke with had completed the appraisal process and had tailored individual development plans. Managers kept records of staff competence, and qualifications.
Managers supported staff to develop through yearly, constructive appraisals of their work. Clinical staff such as registered nurses, health care assistants and allied health professionals participated in a meaningful appraisal.

**Appraisal rates**

From May 2018 to April 2019, 86.8% of required staff in surgery received an appraisal compared to a trust target of 80%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>80%</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>35</td>
<td>36</td>
<td>97.2%</td>
<td>80%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>91</td>
<td>95</td>
<td>95.8%</td>
<td>80%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>78</td>
<td>90</td>
<td>86.7%</td>
<td>80%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>117</td>
<td>141</td>
<td>83.0%</td>
<td>80%</td>
</tr>
<tr>
<td>Additional, professional, scientific and technical</td>
<td>38</td>
<td>53</td>
<td>71.7%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>367</strong></td>
<td><strong>423</strong></td>
<td><strong>86.8%</strong></td>
<td><strong>80%</strong></td>
</tr>
</tbody>
</table>

The trust’s 80% target was met for all staff groups, with the exception of additional, professional, scientific and technical staff. The appraisal completion rate for nursing staff was 93.0%.

The trust did not supply detailed medical staff appraisal data; however, they did provide the trust wide statement below:

For 2018/19 the trust achieved 100% compliance for category 1 medical appraisals. Over this time period, 12% of the total number of doctors eligible for appraisal were classified as category 2 which is approved incomplete or missed appraisal due to qualifying criteria e.g. maternity leave. There were no doctors in category 3 (unapproved incomplete or missed appraisals).

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

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff we spoke with told us they had participated in the appraisal process with their manager where they reviewed their educational needs and set mutually agreed objectives.

Managers trained and supported volunteers to support patients in the service. The trust had robust recruitment checks for volunteers in line with their internal policy. All volunteers completed an application form and had an informal interview with the volunteer coordinator to assess their suitability for the volunteer role. If successful this was followed by a disclosure and baring service (DBS) check, two reference checks and occupational health screening. Volunteers received bespoke volunteer induction training which included: fire safety, information governance,
safeguarding adults and children, manual handling, health and safety, equality and diversity, learning disabilities and autism, infection control and prevention. Any volunteers who worked in clinical areas also received bed making and mealtime assistance training. Specialty volunteers, such as dementia befrienders completed bespoke training specific to their volunteering roles. All volunteers had a named supervisor for their area of work, with full oversight by the volunteer coordinator.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff received a trust induction before they started work in their appointed role, and managers tailored a local induction to the clinical area. Newly qualified nurses had a named preceptor who completed the staff member’s competency sign off. One ward manager showed us the induction packs they gave to student nurses and new staff. The pack provided information about the ward, it detailed patients pathways, such as, the joint replacement enhanced recovery pathway and explained the terminology used within the orthopaedic speciality.

All locum and agency staff received a trust induction pack, which set out the trust values and expectations with useful information and contacts. Locum and agency staff had a local induction checklist which had to be completed on their first shift and delivered to the temporary staffing office within 48 hours.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers we spoke with, told us they monitored staff performance and dealt with any issues promptly. Managers followed the trust’s disciplinary process to manage poor performance of staff which included an action plan for staff to complete, to improve their practice and performance.

Theatre operating staff had to complete competencies for each surgical speciality before they could undertake an operating list without supervision. The theatre manager had a staff competencies and training completion spreadsheet. Recovery staff had comprehensive recovery competencies which included airway and pain management. Theatre rotas were co-ordinated to ensure staff had the right competencies for the planned theatre lists.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers used different methods of communication with staff. Ward staff were encouraged to attend ward meetings where possible, ward managers also used staff notice boards, closed social media groups and news letters to communicate key messages with staff.

Managers made sure staff received any specialist training for their role. The trust had a leadership development programme in place for staff promoted to managerial roles or for staff highlighted for development. Managers we spoke with had either completed this training or were in the process of completing it.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers and staff, we spoke with told us they were encouraged to develop their skills and knowledge. One ward manager told us that they planned to book one of the junior nurses onto the trust leadership course. One member of staff we spoke with had been encouraged to develop their skills being the nurse co-ordinator role on their ward, they felt this had improved their confidence and knowledge of the speciality in a supportive environment.
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. Doctors, nurses and allied health professions held daily board rounds on the wards to discuss patients and plan their care. In theatres surgeons’ anaesthetists and operating department practitioners (ODPs) completed the World Health Organisation (WHO) five steps to safer surgery checklists briefing and debriefing elements appropriately, however this information was not documented in the records.

The service had systems and processes in place to ensure medical outlying patients had a daily consultant review. Staff we spoke with described positive working relationships between medical staff, nursing staff and allied health professionals such as physiotherapists and occupational therapists. We observed staff of all kinds working in a positive way to benefit patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff had access to specialist support for patients, such as, the dementia nurse specialists. Staff communicated with local authority safeguarding teams, social workers, community services and GPs when they planned care for their patients.

Staff communicated important information about a patient’s admission and treatment in the discharge letter sent electronically to the patient’s GP. The meant that the GP had access to patient information in a timely way.

Patient records demonstrated that specialist teams were involved in patient care where required. We saw that the critical care outreach team worked alongside the surgical teams and had input in patients care when required.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The trust had a specialist mental health liaison team based on site every day Staff could request a mental health assessment if they had any concerns about their patient’s mental health.

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 are reviewed by consultants depending on the care pathway. Surgery services provided consultant led care 24 hours a day, seven days a week. Consultants completed ward rounds seven days a week and were available on-call out of hours.

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 service had access to all key diagnostic services such as diagnostic imaging and laboratory services seven days a week to support clinical decision making. Staff had access to mental health support for their patients 24 hours a day seven
days a week. The mental health liaison team were based in the trust from 7am to 7pm and outside of these times staff could contact the crisis response team for support and advise out of hours.

The trust pharmacy department was open from 9am to 5:30pm, Monday to Friday and from 10am to 1pm at the weekends and bank holidays and an on-call pharmacy service outside of normal opening hours to provide clinician support. The trust had plans to extend the pharmacy opening hours at weekends and on bank holiday to mirror weekday opening times, which was due to commence in December 2019.

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. The service had a range of health promotion information available to patients both during their pre-assessment appointment and on the wards. We saw information leaflets on topics such as, smoking cessation, reduction of alcohol intake, reducing deep vein thrombosis risk and fall reduction advice.

Staff discussed and provided information to patients about wound care, driving and exercise prior to their discharge. One member of staff told us, “it is important to put yourself in the patient’s shoes, the more information the better”.

Therapies staff provided support to patients during their rehabilitation. Patients received information about post-operative exercises to increase their mobility and aid recovery from surgery such as, hip and knee replacements. The service had a film that patients could watch to prepare them for orthopaedic surgery rehabilitation.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff in pre-assessment clinic provided patients with health promotion information such as how to prepare for surgery and how to improve their recovery after their surgical procedures. Patients we spoke with told us the nursing staff had provided enough information for them to make decisions about their care and treatment.

All patients had access to smoking cessation support from their clinical teams. The service was provided by an outside organisation, but within the sustainability and transformation partnership.

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 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, had a clear understanding of their role in relation to legislation and how to facilitate consent to care and treatment and safeguard patients with protected characteristics from avoidable harm. Staff had
access to the trust’s Mental Capacity Act and Deprivation of Liberty Safeguard policy through the trust’s intranet page. The policy was within the review date and referenced legislation and national guidance.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained verbal consent for routine daily care treatment such as for assistance with washing, dressing and repositioning. We observed staff gaining consent before delivering care and treatment. Staff gained written consent from patients for all surgical procedures.

Staff clearly recorded consent in the patients’ records. We reviewed 10 patient records, nine of these records were for surgical patients. All nine of the patient records contained correctly completed consent forms for their procedures.

Staff made sure patients consented to treatment based on all the information available. We saw that theatre staff checked the patients understanding of the procedure they were having, which was included in the World Health Organisation five steps to surgical safety checklist. Day care ward staff also checked that patients understood what procedure they had consented for and the information patients had been given. If they had any concerns about the mental capacity of the patient, they arranged for a further consent process to take place with support from specialist staff with a specific consent form for this process.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The trust had green stickers that staff completed and placed in patient records if they identified patients with variable or impaired mental capacity. Staff we spoke with knew that a perceived poor decision did not constitute impaired capacity. Staff on the day care ward told us how they supported patients to make decisions about their care and treatment and accessed support from the learning disabilities lead to assist with the completion of the specialist consent form.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. If a patient was unable to give consent to their care and treatment, staff held a best interest decisions meeting. These meetings were attended by the multidisciplinary team, the patient and their family. In the event of a medical emergency staff provided life saving treatment in the best interest of the patient.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with had access to the trust’s policies through the internal electronic system. Staff told us they had access to further support from the safeguarding team, dementia team and the learning disabilities team when required.

Staff implemented DoL safeguards in line with approved documentation. The service completed one deprivation of liberty safeguarding application from May 2018 to April 2019. This application was made for a patient on ward six and this application was not approved, as the patient had not been assessed by the local authority prior being discharged.

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

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The service met the trust’s target for safeguarding training for nursing staff which
included the Mental Capacity Act and deprivation of liberty safeguards.

**Trust level**

The trust advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust set a target of 90% for completion of MCA/DoLS training.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training courses from May 2018 to April 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>151</td>
<td>152</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>146</td>
<td>147</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery the target was met for both of the adult safeguarding modules incorporating MCA/DoLS training for which qualified nursing staff were eligible, with only one member of staff for each module not completing the training.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training courses from May 2018 to April 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>104</td>
<td>125</td>
<td>83.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>102</td>
<td>124</td>
<td>82.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the target was not met for either of the two adult safeguarding modules incorporating MCA/DoLS training for which medical 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.

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 demonstrated caring, respectful and supportive relationships with their patients and those close to them. We observed staff delivering care in theatres, wards and during their pre-assessment appointments. Staff
interactions with patients were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating patients, and those who were important to them, in a caring and sensitive manner.

Staff followed policy to keep patient care and treatment confidential. Staff treated patients with privacy, respect, and dignity by closing curtains in ward bays and doors of side rooms whilst administering physical and or intimate care. Although we saw that patient name cards were displayed on walls outside the bays on ward areas. We raised this with the senior leadership team for the trust during our inspection and these were removed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff asked patients about their spiritual or religious preferences on admission and this information was used to support patients to receive visits from the chaplaincy team if this was their wish. Staff tailored care to meet patients personal, cultural, social needs and respected their beliefs. Staff ensured they recorded information about patients such as if they were vegetarian or vegan to ensure they had appropriate menu choices and products derived from animals were not used in their care.

Patients said staff treated them well and with kindness. All of the staff we spoke with took pride in their work and were committed to providing the best care they could to their patients. We spoke with seven patients and their relatives who told us they would recommend the service to others. Patients felt the staff cared about them, had been very kind and attended to their needs in a timely way.

**Friends and Family test performance**

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. The table below shows the friends and family test results for surgical wards.

From April 2018 to March 2019 the friends and family test (FFT) response rate for surgery at James Paget University Hospitals NHS Foundation Trust was 48.9%. This was based on 2,491 responses.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 for the period from April 2018 to March 2019 is shown below.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycases</td>
<td>4,453</td>
<td>11%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Ward 5</td>
<td>772</td>
<td>45%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>96%</td>
<td>99%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>524</td>
<td>52%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>99%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>Charnwood Suite</td>
<td>463</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>396</td>
<td>43%</td>
<td>84%</td>
<td>96%</td>
<td>95%</td>
<td>88%</td>
<td>91%</td>
<td>88%</td>
<td>95%</td>
<td>91%</td>
<td>100%</td>
<td>94%</td>
<td>98%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 9</td>
<td>168</td>
<td>46.2%</td>
<td>95%</td>
<td>96%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Key**

Highest score to lowest score

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. Staff had access to a range of specialist services to provide emotional support to their patients such as the chaplaincy service. The trust had an established multi-denomination chaplaincy team, who provided a duty chaplain and on call service supported by a team of volunteers. All non-urgent referrals were responded to on the same or next working day.

The trust had a service level agreement with a mental health service to provide a psychiatric liaison service to patients when the need for additional support was identified.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw that staff closed curtains within the ward bays if patients became distressed to provide additional privacy when attending to distressed patients. Staff told us they would find a quiet space away from other patients where appropriate if patients became very distressed or were to receive 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. Staff we spoke with, understood the impact a patient’s medical condition and their treatment had on the patient’s emotional wellbeing and social interactions with their friends and family. Staff on the day care ward spoke about how they supported patients with a needle phobia or patients with learning disabilities by encouraging family members to be present with them in the anaesthetic room.

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 talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff explaining treatments and discharge arrangements with patients. Staff answered patients’ questions in a way they understood.

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to explain and interact with patients, offering explanations and being supportive when patients expressed concerns.
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Where patients or their families raised concerns, staff took time to listen to the concerns and resolve any issues at the earliest opportunity. Staff we spoke with felt empowered and able to act on concerns or escalate these to a senior member of the team to resolve these at the earliest opportunity.

Staff supported patients to make informed decisions about their care. All patients we spoke with told us staff had provided information about their care and treatment, so they could make decisions. Patients felt they had input into decisions about their care and treatment. We observed that pre-assessment staff prepared patients well for their admission and surgical procedure.

**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 were active members within the Norfolk and Waveney sustainability and transformation partnership (STP). The STP had conducted a review of demand and capacity from 2018 to 2019 to identify work streams across to the STP and align services. The work streams identified for surgery, were ears nose and throat (ENT), urology and vascular surgery. The aim of the STP was to form one clinical team, have one commissioned contract across hospitals and one waiting list. However, this plan meant the transfer of some services to a larger regional hospital in the locality. Managers we spoke with told us they had integrated the urology waiting list with another regional centre within the STP and had plans to extend this way of working to other specialities.

Facilities and premises were appropriate for the services being delivered. The wards and theatres were well equipped and complied with department of health guidelines. The layout of the wards meant that all areas were accessible for people using a wheelchair or walking aids.

Prior to our inspection the trust had increased it standard stock of equipment to support the care of bariatric patients. Staff we spoke with told us they accessed specialist equipment such as bariatric equipment through the trust’s equipment store.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service had separate wards for male and female general surgery patients. Patients on the orthopaedic wards and the day care ward were cared for in single sex bays.

Recovery did not routinely board patients overnight and only had one patient overnight in exceptional circumstances. The service transferred patients to the critical care unit if patients required additional care and monitoring following their surgical procedure.
Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. The trust worked in conjunction with a local NHS trust to provide access to mental health support services 24 hours a day, seven days a week.

The service had systems to help care for patients in need of additional support or specialist intervention. The service has access to additional support services for patients living with dementia or learning disabilities provided by inhouse specialist teams. Staff we spoke with knew how to access extra support and of times they had requested this support. One example, staff gave us was for a patient without mental capacity and this meant the patients consent form was incorrectly completed. Staff contacted the dementia specialist nurse to assist with the correct patient consent process.

**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 trust had a living with dementia support team which was led by a band seven specialist nurse with two more staff in the team. The team completed patient assessments and provided support and advice to patients and staff. Staff told us that the team was easily accessible when required and assisted staff in consent where patients did not have full mental capacity.

The trust had a full-time learning disabilities specialist nurse to provide additional support to patients living with learning disabilities and staff.

The trust had an electronic flagging system that alerted staff when a patient living with dementia or a learning disability was admitted. Staff told us if any patient with an alert was due to be admitted to the ward, they would advise the trust’s liaison nurses, who provided any additional support to the patient and staff which ensured tailored care. The dementia and learning disabilities specialists, supported ward staff in the reasonable adjustments needed to care for people with complex needs individual needs, in line with 'protected characteristics'.

Surgical wards had access to medical consultants for medical patients admitted to surgical wards when there were no medical beds available in the trust. Orthopaedics had one whole time equivalent ortho-geriatrician who primarily assessed frailty trauma patients to provide medical speciality reviews for patients with multiple health concerns. Surgical wards received an email each morning with the details of the medical team responsible for the care of medical outliers. The email included the contact information for each of the teams.

Wards were designed to meet the needs of patients living with dementia. In the 18 months prior to our inspection the trust had commenced a programme of redecoration to support the use of block colours as a visual recognition prompt in all adult inpatient areas. Colour contrast helps patients living with dementia identify hazards in the environment.
Each ward area had activity trolleys to support recreational care planning for patients living with dementia (and others who may benefit). We saw either activity trolleys or boxes on each of the wards we visited. Staff we spoke with, knew where activity resources were kept and made them available to patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust had an enhanced supervision and engagement policy in place to ensure staff developed appropriate patient engagement and therapeutic plans for safe and sensitive monitoring of the patients' physical and psychological well-being, including their conduct and mental health.

The service had information leaflets available in languages spoken by the patients and local community. Staff had access to print patient information in different languages where a patient’s first language was not English. The trust had identified the most common languages spoken in the local population which were available for patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation service through a third-party provider. Staff could request face to face translators for patients whose first language was not English or British sign language. The trust also had access to telephone translation service for situations where admissions were unplanned, or staff were not aware of a need for translation services. Staff we spoke with confirmed they had access to translation services.

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. Staff used the trust’s standardised documentation, which included sections to record patient preferences. Staff developed specialist care plans in response to specific need. The trust used the 'hospital passport' for patients with a learning disability and they were reviewing their approach to using the 'More About Me' document for patients living with dementia.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Arrangements, to treat and discharge patients were in line with national standards.

The service relieved pressure on other departments when they could treat patients in a day. The service had processes in place to manage emergency patients within day surgery. The day care ward admitted patients that attended the emergency department with simple bone fractures and urgent minor surgical procedures to prevent an emergency admission. Patients were able to go home and attend the day surgery ward the next day, staff reassessed patients were safe to continue to follow this pathway.

The day care ward and day surgery theatres had managed the back log of procedures that could be completed as day surgery cases, which had made capacity for emergency day case procedures. Day surgery had made provision to ease day case waiting lists within the local sustainability and transformation partnership.

The manager of the day care ward told us that surgeons from another local NHS trust used
available capacity within the day care theatres and had a urology surgical list every Friday. The divisional management team confirmed this.

**Average length of stay**

Managers and staff worked to make sure patients did not stay longer than they needed to. Surgery performed well in the average length of stay measure for all specialities compared to the England average for elective surgery. Although specialities such as trauma and orthopaedics and general surgery were 0.1 days above the England average. These specialities undertook a large proportion of elective major procedures.

**James Paget Hospital**

From February 2018 to January 2019 the average length of stay for patients having elective surgery at James Paget Hospital was 3.2 days. The average for England was 3.9 days.

**Elective Average Length of Stay - James Paget Hospital**

![elective length of stay graph]

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

- The average length of stay for patients having elective trauma and orthopaedics surgery at James Paget Hospital was 3.8 days. The average for England was 3.7 days.
- The average length of stay for patients having elective general surgery at James Paget Hospital was 4.0 days. The average for England was 3.9 days.
- The average length of stay for patients having elective urology surgery at James Paget Hospital was 2.2 days. The average for England was 2.5 days.

The service performed worse than the England average for average length of stay for non-elective admissions. Prior to our inspection the service had introduced an initiative to reduce the length of stay for patients. Patients were assessed and could be admitted for emergency day case surgery. Managers we spoke with expected to see an improvement in the average length of stay and waiting list reduction in early 2020.

For patients having non-elective surgery, the average length of stay was 6.0 days. The average for England was 4.7 days.

**Non-Elective Average Length of Stay - James Paget Hospital**

![non-elective length of stay graph]
• The average length of stay for patients having non-elective general surgery at James Paget Hospital was 4.7 days. The average for England was 3.7 days.
• The average length of stay for patients having non-elective trauma and orthopaedics surgery at James Paget Hospital was 9.2 days. The average for England was 8.4 days.
• The average length of stay for patients having non-elective urology surgery at James Paget Hospital was 3.6 days. The average for England was 2.7 days.

(Source: Hospital Episode Statistics)

Managers and staff worked to make sure that they started discharge planning as early as possible. Consultants held daily ward rounds to assess their patients and provide a plan of care. Discharge information was discussed at daily bed meetings chaired by the director of nursing or their deputy. This allowed managers to plan bed capacity and flow through the hospital.

The service used the day care ward to admit elective patients prior to their surgical procedure when patients planned for discharge had not left the hospital. This prevented delays to the planned procedures or cancellations.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Managers monitored waiting times. The divisional management team monitored the time from referral to treatment times and they acknowledged the challenges they had due to consultant vacancies and increased urgent care demands. The service had increased capacity in ophthalmology and started weekend theatre lists in order to reduce waiting list for specialities such as orthopaedics.

From April 2018 to March 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average in all 12 months. It ranged from 57.0% to 64.2%, compared to the England average of 63.3% to 68.3%.

In the most recent month, March 2019, 58.5% of this group of patients were treated within 18 weeks compared to the England average of 63.3%.
Referral to treatment (percentage within 18 weeks) – by specialty

From April 2018 to March 2019, three 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>81.6%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>72.7%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>71.8%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

Three 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>General surgery</td>
<td>64.8%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>55.2%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>48.5%</td>
<td>58.5%</td>
</tr>
</tbody>
</table>

The divisional management team acknowledged they had not performed well in the RTT for general surgery and trauma and orthopaedics. The management team had plans in place to increase theatre capacity by refurbishing a theatre that was not used. The service had changed the theatre utilisation plans to enable additional capacity for specialities to reduce their waiting lists. This initiative was in the early stages and at the time of our inspection there was no data available to demonstrate the change was effective.

The trust had increased clinical and treatment room capacity to improve the RTT for ophthalmology. The division had processes in place to increase nurse led procedures such as eye injection procedures to increase consultant capacity for ophthalmic surgery.

Cancelled operations

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. The service performed well in the percentage of patients whose operation was cancelled and were not treated within 28 days compared to the England average.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of...
the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period from quarter 1 of 2017/18 to quarter 4 of 2018/19 (April 2017 to March 2019), the percentage of last-minute cancellations at the trust where the patient was not treated within 28 days was consistently lower than the England average.

In quarter 2 of 2017/18, this trust cancelled 133 surgeries. Of the 133 cancellations, 2% weren’t treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - James Paget University Hospitals NHS Foundation Trust**

Over the two-year period, the percentage of cancelled operations at the trust was, in the most part, lower than the England average. There was a deterioration in the trust’s performance in quarter 2 of 2017/18 (July to September 2017).

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

Managers worked to keep the number of cancelled operations to a minimum. The service performed well compared to the England average in the total number of cancelled operations.

**Cancelled Operations as a percentage of elective admissions - James Paget University Hospitals NHS Foundation Trust**

(Source: NHS England)
Patient moving wards per admission

From May 2018 to April 2019, 57% of individuals in surgical ward 5 (male general surgery, urology and ear, nose and throat) did not move wards during their admission, and 43% moved once or more.

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

Staff did move low numbers of patients between wards at night. Staff tried to minimise the movement of patients at night, however managers we spoke with told us they moved patients to ensure that patients received the right care in the right place at the right time.

Patient moving wards at night

From May 2018 to April 2019 there were 377 patients moving wards at night within surgery (10.4% of all ward moves at night trust-wide). The month with the highest number of ward moves at night was January 2019 with 67. A breakdown of numbers of moves by ward is in the table below.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Number of moves</th>
<th>Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 5 (male general surgery, urology and ear, nose and throat)</td>
<td>205</td>
<td>54.4%</td>
</tr>
<tr>
<td>Ward 6 (trauma and orthopaedics)</td>
<td>95</td>
<td>25.2%</td>
</tr>
<tr>
<td>Charnwood Suite (private patients)</td>
<td>40</td>
<td>10.6%</td>
</tr>
<tr>
<td>Ward 22 (elective orthopaedics)</td>
<td>37</td>
<td>9.8%</td>
</tr>
<tr>
<td>Total</td>
<td>377</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

Managers worked to minimise the number of surgical patients on non-surgical wards. During our inspection there were no patients on non-surgical wards. Although surgical wards did have low numbers of medical outlier patients. We found one or two medical outliers on ward four, ward five and ward six, however ward 22 and the day care ward had no medical patients.

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. Patients and their relatives we spoke with told us they knew how to make a complaint. Although all patients we spoke with were happy with their care and said they had no reason to complain.

The service clearly displayed information about how to raise a concern in patient areas. We observed posters with information about the patient advocacy and liaison services (PALS) displayed in corridors. We did not see information leaflets within patient care areas.
Summary of complaints

From June 2018 to May 2019 the trust received 39 complaints in relation to surgery (17.4% of total complaints received by the trust). The main subject of complaints was all aspects of clinical treatment (21). A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of clinical treatment</td>
<td>21</td>
</tr>
<tr>
<td>Communications</td>
<td>6</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>4</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

For the 22 complaints that had been closed at the time of data submission, the trust took an average of 94.2 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 60 working days.

The 17 complaints that had not yet been closed had been open for an average of 90.1 working days at the time of data submission.

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

Information provided by the trust stated that 100% of complaints were resolved within 60 working days. This was different to the complaints data we received. Ward managers we spoke with told us they completed timely investigation following complaint and sent the reports to the complaints team. The divisional managers told us that if staff were unable to provide a timely response, they kept patients and families informed throughout the process. Managers met with patients and families to help resolve their concerns and complaints.

Staff understood the policy on complaints and knew how to handle them. Staff and managers, we spoke with understood their responsibilities in relation to the trust’s complaints policy. They told us they tried to resolve patient concerns and complaints at the earliest opportunity, and they worked with patients do this.

Managers investigated complaints and identified themes. Managers we spoke with told us they completed complaint investigations related to their ward or clinical area and sent the reports to the complaints department. The divisional leadership discussed complaints and any emerging themes within divisional governance meetings. Complaints information was used to improve care by staff education or physical changes to the patient care environment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with knew how to deal with patient complaints and concerns and tried to resolve any issues locally. In the event they were unable to
resolve issues themselves they told us they would escalate the concerns to their manager. Managers investigated patient complaints and provided feedback to patients.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us they received learning following complaints. Staff on the day care ward gave us an example about a complaint which was also reported as a serious incident and how changes were made to practice following the complaint and incident. Staff also told us they would report patient complaints and concerns through the trust’s incident reporting system.

**Number of compliments made to the trust**

From May 2018 to April 2019 there were 138 compliments received for surgery (17.9% of all received trust wide).

Compliments were received in 11 of the 12 months of this period. November 2018 was the month where the most compliments were received (61).

The trust did not provide a breakdown by subject for compliments received.

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, 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 senior leaders for the service know their strengths and challenges in relation to service demands, resources and the provision of safe good quality care. Leaders had clearly defined plans for service improvement and succession planning. The service was in the process of transition with changes to the lead nurse for the division. There was a planned overlap between the departure of one manager to another to provide continuity to the service.

A team of dedicated and proactive ward managers and matrons supported the service leadership team who received praise from the staff they managed. Each manager was fully versed in the challenges and areas of good practice in their individual areas and committed to making positive change. Staff stated that they felt valued and supported in their role.

We observed strong leadership at a local level staff praised their local managers and said they supported them and communicated with them regularly. Staff we spoke with told us their divisional managers were routinely visible and approachable.

Ward managers we spoke with had completed or were in the process of completing the trust’s leadership course. Ward managers had also identified junior staff to be nominated for the leadership course to aid future succession planning.
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 service had a vision to integrate surgical services with other trusts within the local sustainability and transformation partnership. The vision was to have one team across the partnership organisation and one waiting list. The service had completed the transition for the urology service and had further integration plans with other specialities to follow, such as, ear, nose and throat service.

Senior managers told us that the imminent strategy, was maintenance and sustainability, due to changes within the senior team. The team planned to refresh the divisional strategy once the new members of the team had completed their corporate and local inductions. Leaders spoke of the importance of developing staff to progress into leadership roles to sustain the service.

The trust had a set of organisational values. Staff we spoke with knew the organisation values of:
- Courtesy and respect
- Attentively kind and helpful
- Responsive communication
- Effective and professional

Staff displayed these values at all times during our inspection.

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 reported an open and honest culture and said they felt able to raise any concerns with their managers. All staff we spoke with confirmed that the needs and experience of their patients was at the centre of the service. Staff told us they could raise concerns without the fear or reprimand and they were confident action would be taken as result.

Staff had access to independent freedom to speak up guardians to express any concerns outside of their immediate teams if they needed to.

Staff morale was good and staff we spoke with confirmed they felt valued and well supported by colleagues and managers within their roles. Managers praised staff for their commitment and team working to meet the needs of patients and the service.

The trust had staff awards called the ‘remarkable people’. Staff members and teams could be nominated for an award by patients and other staff members for going the extra mile for patients in their care. Most of the areas we visited had been nominated for an award either as a team or individual who worked in the area.
The trust participated in the NHS staff survey. The last staff survey conducted from 2018 to 2019 showed an improvement in the measure of the percentage of staff believing that the organisation provided equal opportunities for career progression or promotion. Results showed that 91.7% of staff agreed with this statement compared to 88% of staff in the previous year. The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months had improved with 22.1% reporting bullying and harassment compared to 27% on the previous year.

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 set out clear roles, responsibilities, and systems of accountability to support good governance and management of the service. Staff we spoke with described the service’s management and governance structure and their specific roles and responsibilities.

The service had effective data collection processes, which provided the management team with service level assurance. The surgical division governance committee was responsible for reviewing clinical governance information from audits, and safety and quality improvement initiatives.

Managers we spoke with told us, there were additional specialty governance meetings across the division and organisation which provided opportunities for shared learning including the mortality and morbidity meetings, local audit meetings and a cross-divisional learning forum.

Ward managers met monthly to discuss incidents, learning, key messages and audit results. This provided peer support and networking opportunities for ward managers. We requested minutes for the ward managers meetings, however managers did not minute these meetings.

Ward managers shared information such as key messages and incident learning during staff handovers and team meetings. Ward managers told us that they communicated important information at team meetings with staff and by email or the staff notice boards, for when staff were unable to attend ward meetings or had been on leave.

The non-executive directors actively adopted key leadership roles as board committee chairs and had designated lead roles. For example, the safety and quality governance committee, this committee reviewed assurance reports from the divisional patient safety and effectiveness committee and other safety and quality work streams such as the mortality surveillance group and the health and safety committee.

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 clear processes for managing risks issues and performance. The service had an electronic risk register linked to the incident reporting system. The trust used risk registers based on the potential consequence of the risk and the likelihood of the risk happening again. The trust used a red, amber, green risk rating system, to denote the high, medium and low risk. Each risk had a rating on entry to the register and a rating once mitigations were in place. All risks had a review date, a named owner, and an action plan.

The surgical division had five risks on their risk register. Each risk entry had a clear description of the risk and mitigation in place to reduce the impact of the identified risk. There were regular updates added to the risk register by the risk owner. There were two risks rated as high for emergency caesarean sections as midwives did not always have theatre scrub competencies to support maternity theatres out of hours. The service had mitigation in place with staff gaining additional training outside the trust. The other risk related to medical consultant staffing, the trust had ongoing recruitment to fill the vacant posts.

Senior managers discussed the divisional risks within the divisional governance meeting. We reviewed the divisional governance meeting minutes from April 2019 to August 2019 which demonstrated that risks were discussed, we saw that teams requested increased or decreased risk ratings, which were discussed by the senior leadership team before any action was granted.

Wards and clinical areas did not hold an individual risk register, all risks were held on a service wide risk register. Ward managers took ownership of risks directly related to their area of responsibility, they monitored risks and discussed risk mitigation actions taken with their managers.

Managers monitored performance against internal key performance indicators and the care quality commission key lines of enquiry. Performance against these measures was discussed at the speciality operations meeting which reported to the divisional governance meetings, where any improvement action plans were agreed. We observed that the divisional board reviewed performance measures, such as, mandatory training, appraisal compliance, cost improvement programme (CIP) savings and local quality monitoring audit results.

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 across the trust accessed information from the trust intranet which included policies and national guidance. Staff knew how to access information through the intranet in each of the areas we visited.

The service used both paper and electronic patient records. Care planning and records of care were hand written in paper records and medicine prescriptions were electronic. We found that paper records were kept in trolleys within staff areas, although the trolleys were not secure or kept in locked areas. Electronic records were secured through individual login and passwords.
Theatres used electronic patient records where information about the use of implants and traceability were recorded. Managers used the electronic patient records for audit purposes and to monitor the completion of the World Health Organisation (WHO) five steps to surgical safety.

The service collected audit data to monitor the safety and effectiveness of the service. Specialities within the service provided audit information to national audits such as the national hip fracture audit to gauge their effectiveness compared to other trusts in England. The service used this information to inform service improvements.

**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.

Managers told us they had regular meetings with the local clinical commissioning group to discuss performance and key performance indicators.

Staff had an opportunity to provide feedback about working for the organisation. Staff participated in the NHS staff survey undertaken in 2018. The service had an action plan in place to act on feedback from staff. For example, actions taken by the service was to focus on staff wellbeing in line with the trust’s staff wellbeing strategy.

The service held team meetings monthly and staff confirmed that there was good teamwork and engagement.

The trust had staff awards where staff and patients could nominate individual staff members or teams for going the extra mile. Staff we spoke with told us about these awards and several staff members told us their team had been nominated for an award.

The service participated in the NHS friends and family test. Patients and their relatives could provide additional feedback through links on the trust’s public website. The public website also provided information and news about the trust for service users.

**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 trust had a strong focus on quality improvement. We saw quality improvement pilots across surgery services, such as, the ‘mission to reposition’ on ward six to prevent service acquired pressure ulcers. On ward four staff assessed lying and standing blood pressure for all newly admitted patients as part of the initiative for the prevention of falls. The day care ward and pre-assessment were piloting an initiative for venous thrombo-embolism patient education.

The service was participating in a global research trial, for a new treatment to tackle a condition which causes blindness. The trust’s ophthalmology team had a non-medical team to deliver the
intra-vitreal injection service, a treatment for age-related macular degeneration (ARMD). The divisional management team told us they had upskilled specialist nursing staff to undertake this procedure which had freed up consultant capacity to meet demands in other areas of the ophthalmology service.

The service had won awards for their surgical training programme. Theatres supported education for undergraduate and post graduates by live streaming, virtual reality, actual reality and video recording surgical procedures within specialties such as breast surgery, general surgery, orthopaedics and ENT which linked with the local university who provided medical training.

The service had a colorectal enhanced recovery programme in place to prepare patients for major surgery and pathway of care to optimise recovery. This meant that patients had a shorter recovery following colorectal surgery which reduced their length of stay. This provided benefits to patients and the service.

**Critical care**

**Facts and data about this service**

The trust has 12 critical care beds, which can flex between intensive care and high dependency. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, James Paget University Hospitals NHS Foundation Trust and England**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 14.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, 85.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal, 24.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, 70.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

During the inspection we spoke with three consultants, five doctors, 12 registered nurses (RN) one health care assistant, one physiotherapist and one assistant pharmacy technician. We spoke with four relatives and one patient. We reviewed four patient medical records and various policies and meeting minutes.

**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 however, not everyone had completed it.

Mandatory training completion rates
The trust set a target of 90% for completion of mandatory training. Mandatory training was as face to face sessions or by online learning modules.

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety for managers</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>60</td>
<td>60</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>59</td>
<td>60</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>59</td>
<td>60</td>
<td>98.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>58</td>
<td>60</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical gases</td>
<td>51</td>
<td>60</td>
<td>85.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>51</td>
<td>60</td>
<td>85.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>48</td>
<td>60</td>
<td>80.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>43</td>
<td>60</td>
<td>71.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>39</td>
<td>60</td>
<td>65.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In critical care the trust had an overall mandatory training compliance rate of 89.0% for qualified nursing staff. The 90% target was met for nine of the 14 mandatory training modules for which qualified nursing staff were eligible.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The mandatory training was comprehensive and met the needs of patients and staff. Staff had also received training on sepsis management, including the use of sepsis screening tools and use of sepsis care bundles from the clinical care outreach team (CCORT).

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. In critical care the trust had an overall safeguarding training compliance rate of 93.3% for qualified nursing staff. The 90% target was met for all six safeguarding training modules for which qualified nursing staff were eligible.

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

The table below includes prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>54</td>
<td>60</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>57</td>
<td>60</td>
<td>95.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT (WRAP) – One off</td>
<td>55</td>
<td>60</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) - 3 Yearly</td>
<td>58</td>
<td>60</td>
<td>96.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the nursing and medical staff we spoke with knew how to raise a safeguarding concern.

Staff had displayed a list of contact numbers for the trust wide safeguarding team at the nurse station for ease of access.

Cleanliness, infection control and hygiene

Staff 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.

The ward had four rooms which had pressure control. This meant these rooms could be used for respiratory isolation of patients requiring this treatment.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All ward areas we visited were clean, tidy and free from clutter. Equipment and furnishings were wipe clean and in good condition.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff had bare arms below the elbow in line with department of health guidelines and staff wore disposable gloves and aprons when providing direct patient care.

Staff cleaned equipment after patient contact. Nursing staff cleaned equipment at the patient bed side before moving it to the store room when it was no longer required. This was in line with the ward policy.
Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records demonstrated staff cleaned all areas in line with trust policy. The ward monthly environmental cleanliness audit data showed greater than 98% compliance from August 2018 to July 2019. This was better than the trust target of 95%. Housekeeping staff damp dusted the patient bed space twice each day and had replaced fabric curtains in line with the trust wide policy and dated them to record when this had been done. Hand hygiene audit data for July 2019 and August 2019 showed staff on the ward were 100% compliant.

The ward reported 1498 days without a case of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and 209 days without a case of Clostridium difficile (C.Diff) bacteraemia which evidenced good cleaning practices.

Visitors were required to follow infection control protocols. Staff requested them to wash their hands and use alcohol sanitiser on arrival and explained why. Hand sanitiser was freely available, clearly signposted and visible.

**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.**

Staff, patients and visitors accessed the ward through two sets of secured double doors. Nursing staff had closed circuit television (CCTV) monitors at the nursing station so they could view who was asking to come in.

The ward was effectively long and thin with eight side rooms, four curtained bays, two relatives’ rooms, two nurse stations and a number of store rooms. The ward had one patient shower room and one which was for the use of family staying in the relative’s rooms.

Patients could reach call bells and staff responded quickly when called. Staff cared for patients on a one to one basis or a one to two basis. This meant that patients did not need to use call bells to alert nursing staff although call bells were in reach for those patients who were conscious.

The design of the environment followed national guidance. The facilities in the CCU conformed to the Department of Health guidelines for critical care facilities (Health Building Note 04-02). The bed spaces were of a suitable size, allowing enough space for up to five staff to work safely with a patient in an emergency. There were separate buttons for patient call bells and emergency calls. There was also an intercom at each patient’s bed space so staff could communicate without leaving their patient.

There were two specialist patient isolation rooms to minimise infection cross-contamination with air change facilities and changing lobbies for staff and visitors. These were located at the far end of the unit and could be accessed if necessary without entering the main part of the unit.

Staff carried out daily safety checks of specialist equipment. The electronic record system required checks of equipment and the environment to be recorded individually. For example, oxygen, suction, the ventilator, monitors, pumps, the bed and patient bed space were checked for different safety elements.

The service had suitable facilities to meet the needs of patients’ families. The ward had two designated family rooms with access to a shared toilet. Rooms had comfortable seating and space...
for fold out beds. Family members also had access to the Louise Hamilton Centre which was an onsite facility where they could have showers.

The service had enough suitable equipment to help them to safely care for patients. Each patient bed space had suitable equipment to provide level two and level three care. Level two, or high dependency care, is when patients need single organ support (excluding mechanical ventilation). Level three, or intensive care patients, require two or more organs to be supported or need mechanical ventilation alone.

The ward had two resuscitation equipment trolleys. One at either end of the ward. Staff checked resuscitation equipment in line with trust wide policy and records evidenced no omissions. There were resuscitation medicines and equipment including defibrillators and an intubation trolley for complex and difficult airways. There was also suitable paediatric equipment.

The CCU had facilities for completing some near patient medical tests within the unit. The ‘near-patient’ or ‘point of care’ services included testing of blood gases, blood glucose, and CO-oximetry. Staff were trained to use the equipment by staff from the hospital laboratory.

Nursing staff stored equipment and consumables appropriately. We randomly checked a selection of consumables including syringes and dressings and found they were in date for use and stored appropriately.

Staff disposed of clinical waste safely. Staff disposed of single-use items of equipment appropriately, either in clinical waste bins or sharps containers. None of the waste bins or containers for disposal of clinical waste or sharp items we saw were overfilled.

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.

Patients in the CCU were nursed by recommended levels of nursing staff at all times. Patients who were classified as needing intensive care (level three) received one to one nursing. Patients who needed high dependency care (level two) were cared for on a ratio of one nurse for every two patients. This level of nursing supervision enabled any clinical changes for the intensive and high dependency patients to be promptly responded to.

Staff monitored patients for different risk indicators. Each ventilated patient on the CCU was, for example, monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Monitoring equipment was available in each bed space on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.

The hospital did not provide 24 hour cover from the critical care outreach team (CCORT). The CCORT service was not available at night when deteriorating patients became the responsibility of the hospital at night team. The CCORT service was provided by experienced and skilled nurses from 7am to 7:30pm, 365 days a year. The guidelines for the Provision of Intensive Care Services 2015 (Faculty of Intensive Care Medicine, Intensive Care Society, and others) recommended outreach services be provided 24 hours a day. The hospital at night team were skilled clinical practitioners and supported by consultants at night, but they had a multiple focus across the whole site and were not critical care trained. The critical care service leaders described how the CCORT were becoming a 24 hour service from October 2019.
Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital used a vital signs monitoring tool based on the National Early Warning Score (NEWS) which is a standardised tool to detect the deteriorating patient. Patient observations were completed automatically and electronically at the bed side on a 15 minute basis and verified by the nurse caring for the patient at a set time interval, usually two hourly.

When a ward-based patient triggered a high risk score from one or a combination of indicators, a number of appropriate routes would be followed by staff. One of the triggers would include a review of the patient by the critical care outreach team or the hospital at night team. The outreach team had been established to support staff on wards with all aspects of the critically ill patient, including early identification of patient deterioration. The outreach team or the patient’s medical team were able to refer the patient directly to one of the CCU consultants for support, advice and review.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. Staff completed risk assessments on each patient on admission and regularly during their stay on the ward. These included assessments for venous thromboembolism (VTE), pressure ulcers, and malnutrition. Staff had completed and updated these appropriately in the four patient records we reviewed.

Staff knew about and dealt with any specific risk issues. (Consider reporting sepsis, VTE, falls and pressure ulcers) The trust had developed a number of tools: red flag sepsis recognition stickers and a sepsis six sticker which reflected the UK Sepsis Trust guidance. The Critical Care Outreach Team (CCORT) had engaged with CCU staff to provide education around sepsis. The trust had implemented a patient group directive (PGD) for the CCORT nurses to ensure that a dose of intravenous (IV) antibiotics can be given in the case of red-flag sepsis within the golden hour if ever there was a medical delay.

The consultant microbiologist provided ward reviews daily for CCU patients where they reviewed antibiotic prescriptions and microbiological sample results. The visits provided an educational opportunity for the junior doctors.

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) (AMSAT). Staff could access the trust wide mental health service 24 hours every day of the week.

Staff accessed the substance misuse service Monday to Friday between 9am and 1pm with an on call service available outside those hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff referred patients for mental health assessments once they were medically stable.

Staff shared key information to keep patients safe when handing over their care to others. Ward rounds in the CCU took place twice daily; in the morning and evening, in the seminar room and not at the patient bedside. This allowed for increased patient confidentiality. Ward rounds were led by the consultant on duty each day. Ward based staff, including at all times the doctors and the nurses caring for the patient, attended the ward round and added their input. The supernumerary senior nurse (sister or charge nurse) attended the whole ward round. The critical care outreach (CCORT) nurses also attended. This meant patients who were deteriorating or at risk of deterioration elsewhere in the hospital could be discussed for possible admission to the CCU.
We attended a ward round and noted all patients being cared for in the CCU were discussed. All staff contributed to the ward round and were able and encouraged to ask questions about aspects of patient care such as skin integrity, nutrition and hydration. Discussions were also personalised around patients’ holistic care including whether the patient had contact with family or if social services were involved. The patient test results and observations were displayed on a projector screen in the meeting room during the ward round and reviewed for each patient.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff carried out a nurse to nurse hand over at the patient bed side at each shift change. Nurses handed the patients over to the new shift following a set protocol. Patients were discussed in relation to updates on their risks, including communication, hygiene, malnutrition, fluid balance, pain, psychological markers, sleep or ability to rest, and risk of falls. Nursing staff had a patient schedule which covered all the patients admitted to the unit and provided nurses with relevant information in order to provide safe and effective care. This included information related to any patients who wished not to be resuscitated in the event of a cardiac or respiratory arrest do not attempt cardio pulmonary resuscitation (DNA CPR), patients living with dementia or other cognitive impairment, and other essential information, for example falls risks.

**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. (Include reference to other staff groups such as AHPs if the evidence supports this.)

The table below shows a summary of the nursing staffing metrics within critical care at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.

<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>77</td>
<td>3%</td>
<td>13%</td>
<td>6.2%</td>
<td>287 (&lt;1%)</td>
<td>642 (&lt;1%)</td>
<td>886 (&lt;1%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>67</td>
<td>3%</td>
<td>15%</td>
<td>6.6%</td>
<td>287 (&lt;1%)</td>
<td>642 (&lt;1%)</td>
<td>886 (&lt;1%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, bank use or agency use.

The service had enough nursing staff of relevant grades on each shift to keep patients safe. Each shift was staffed by a minimum of eight registered nurses (RN) with a supernumerary nurse in charge (NIC) and one health care assistant (HCA).

The ward manager could adjust staffing levels daily according to the needs of patients. Ward managers increased or decreased the numbers of nurses required on each shift depending on patient acuity.

Senior nursing staff were generally not counted in the direct-care staffing numbers (supernumerary) in order for them to manage the ward and nursing teams. The Faculty of Intensive Care Medicine (FICM) core standards recommended a supernumerary clinical coordinator on duty at all times for a ward of this size.

The staff rota demonstrated there was at least one senior supernumerary nurse on duty at all times. However, there were times when the ward was busy and an unplanned new patient admission was made which meant that the nurse coordinator was required to directly care for a patient. The senior nurses we spoke with said this would usually be addressed with additional staff being rostered to the next shift and the supernumerary coordinator being released to manage the ward.

The number of nurses and healthcare assistants on all shifts on each ward did not match the planned numbers. On both days during our inspection the planned (11) and the actual number (eight) of registered nurses (RN) on each shift did not match. However, senior sisters kept patients safe by including themselves in the nursing numbers where required.

Service leaders described ongoing recruitment processes and international recruitment. Service leaders had introduced an apprenticeship scheme to upskill health care assistants and enable career progression to registered nurse grade.

**Vacancy rates**

![Vacancy rate - qualified nurses, health visitors and midwives](chart)

Monthly vacancy rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed a downward trend from October 2018 to February 2019.
The ward had reducing vacancy rates, at or below the trust target and was actively recruiting for four WTE RN.

**Sickness rates**

![Sickness rate chart]

Monthly sickness rates from May 2018 to April 2019 for qualified nurses, showed a shift from November 2018 to April 2019.

**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 locum staff a full induction.

The service had enough medical staff to keep patients safe. The CCU was led by an experienced consultant clinical lead supported by a skilled team. The clinical lead was a consultant in intensive care medicine and Fellow of the Faculty of Intensive Care Medicine (FICM). All eight consultants working on the primary rota were consultant intensivists and therefore highly experienced in delivering care to some of the most critically ill patients in the hospital.

The level of cover provided by consultant staff exceeded professional standards. The experienced consultant presence on the CCU followed the recommendations of the FICM Core Standards.

There were eight consultant intensivists (consultants trained in advanced critical care medicine).
working in rotation in critical care and on call. There was a good consultant to patient ratio. There was one consultant on duty or on call across the CCU for an absolute maximum of 12 beds, with usually (unless there was a critical incident) a maximum of eight patients at the highest level of critical illness (level three). This was better than the core standards recommended ratio of one consultant for a maximum of 15 patients.

The FICM Core Standards required consultants to have a minimum of 15 programmed activities (PA) of consultant time committed to critical care each week and this was met and generally exceeded. The consultants worked in seven-day blocks, consultant of the week system, so there was a consistent level of involvement on the unit among the team.

The medical staff matched the planned number on all shifts in each department. One of the consultant intensivists was on duty from 8am to 8pm and a second from 7pm to 1am, unless it was risk assessed as safe for the second consultant to go home earlier and be on call. Consultants attended the units out of hours when needed and often took calls from staff. This arrangement covered seven days a week with no difference in the level of cover on the weekends or public holidays.

The service always had a consultant on call during evenings and weekends. When consultant intensivists were on duty or on call, this was only for critical care and did not include elsewhere in the hospital.

The service had a good skill mix of medical staff on each shift. Medical cover for each shift was always the consultant of the week supported by two junior doctors and a ward-based consultant. Overnight, the medical cover for the ward was provided by a junior doctor with an anaesthetic background and a consultant on call.

The service had reducing vacancy rates for medical staff. The trust had recently appointed a doctor who was due to take up their position on the ward within the next few weeks.

**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.

Patients’ treatment plans were clear and could be followed through the electronic records. We reviewed four sets of notes in the electronic record system. Nursing staff recorded the decision and time to admit as timely (less than one hour) or delayed. Each patient record included a summary of the events leading to admission to critical care, and the consultant assessment upon admission.

Nursing staff completed risk assessments on admission and reviewed them appropriately. These included assessments for venous thromboembolism (VTE), pressure ulcers, and malnutrition. There were care plans for managing or preventing conditions such as ventilator-associated pneumonia sepsis. Reviews and documentation included medical lines and devices, fluid balance, use of sedation and antibiotics, the prescription of medicines, nursing care plans and vital sign observations. All four records were up-to-date, and all staff signed into the system so records made were attributable to the member of staff caring for the patient and automatically timed and dated.

Records were stored securely. Staff stored patient records securely and confidentially. The electronic system meant patient records could only be accessed by staff with authorised access.
Staff kept patient information confidential by turning papers face down and locking computer screens when they left them.

Patient notes were comprehensive, and all staff could access them easily. Nursing staff updated patient medical records at the bedside. This ensured records were contemporaneous and enable nurses to provide continuous patient monitoring.

When patients transferred to a new team, there were no delays in staff accessing their records. Nursing staff completed discharge summary packs which were paper based and transported these with patients when they were discharged to wards. These records contained information on recovery after a stay in critical care, a check list for central line care and a national early warning score (NEWS) sheet which was completed on handover of care.

**Medicines**

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

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored safely and appropriately in a room locked with a coded keypad and were well organised. The keys for the controlled drug cupboards, within the locked room, were held by the nurse in charge on each shift.

Controlled drugs were managed in line with legislation and NHS regulations. The drugs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. We checked drugs in tablet (all boxed) and liquid form all of which were stored appropriately.

Records demonstrated nursing staff monitored and recorded fridge temperatures in line with trust policy.

Staff followed current national practice to check patients had the correct medicines. Staff confirmed the patient identity with those patients who were able to verbalise. Staff described how they would confirm the patient identity of those patients who were sedated or nonverbal.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Consultants enquired about patients’ mental health. One patient on the ward at the time of inspection was very anxious. The consultant spoke with the bedside nurse and offered to write up a prescription for medication to relax the patient if required. The nurse described how chatting with the patient and keeping the observation monitor turned away from them was helping alleviate their concerns at that moment.

Nursing staff described a sedation assessment which they completed on sedated patients every two to four hours to ensure the level of sedation was appropriate. None of the records we reviewed evidenced patient behaviour was inappropriately drug controlled.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff used electronic prescribing to administer and record patient medicines. We observed staff administering medicines on the wards. They checked medicine prescription allergies and for dosage. Staff checked patients’ wrist identity bands against the prescription record before they gave patients their medicines.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. The pharmacist reviewed patient medicines daily and could do this remotely from the pharmacy department.
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.

Staff knew what incidents to report and how to report them. All the staff we spoke with were able to describe the process for incident reporting and what type of things it would relate to. Managers we spoke with told us they had an open reporting process to learn from incidents or near misses.

Staff reported all incidents that they should report. The national reporting and learning system (NRLS) and strategic executive information system (StEIS) demonstrated that staff reported incidents appropriately.

There was evidence that changes had been made as a result of feedback and learning from incidents. Two nursing staff described how they secured naso-gastric tubes to the patients face using a new technique after an incident where a previous patient had developed a pressure ulcer on their nose.

Never Events

The service had one never event on the ward. 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 May 2018 to April 2019, the trust reported one incident classified as a never event for critical care. This was a misplaced naso-gastric tube, which occurred in February 2019.

(Source: Strategic Executive Information System (STEIS))

All the staff we spoke with knew in detail about the incident and the relating investigation. Staff knew what additional precautions had been put in place to prevent it occurring again.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in critical care which met the reporting criteria set by NHS England from May 2018 to April 2019. This was a surgical/invasive procedure incident which occurred in February 2019.

Please note, this is the same incident classified as a never event above.

(Source: Strategic Executive Information System (STEIS))

Staff discussed incidents at the monthly clinical governance and mortality and morbidity meetings. Meeting minutes dated 31 July 2019, showed the meeting was well attended by staff of all
appropriately grades and roles and that there had been no serious incidents or patient concerns to discuss.

All the staff we spoke with were aware of the duty of candour regulation. 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. A patient medical record we reviewed showed where a consultant had carried out the duty of candour verbally and followed this up with a letter.

Staff discussed learning from deaths at the monthly clinical governance and mortality and morbidity meetings. Meeting minutes dated 31 July 2019, showed the meeting was well attended by staff of all appropriate grades and roles. Staff reviewed three deaths and feedback and learning from them was shared.

**Safety thermometer**

The service used monitoring results 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 one new pressure ulcer, no falls with harm and one new catheter urinary tract infection from April 2018 to April 2019.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers and catheter acquired urinary tract infections at James Paget University Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (1)</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

12
8
4
0
Senior nurses discussed the safety thermometer as part of monthly senior sisters’ meetings and also at the monthly governance meeting. Meeting minutes dated 31 July 2019 confirmed this. However, safety thermometer data was not always valuable due to the nature of the patients on the ward. Ward managers told us the elevated score for urinary tract infections (October 2018) was due to a data error.

Senior nurses discussed pressure ulcers and falls as part of the ward dashboard which looked at key performance indicators (KPI).

In accordance with best-practice, the CCU published avoidable patient harm data within the unit for patients, relatives and staff to see. This showed how many days had elapsed since, for example, the last pressure ulcer, fall with harm, or incidence of methicillin-resistant Staphylococcus aureus (MRSA).

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 had access to policy and guidance documents on the trust’s intranet. We observed staff accessing policy and guidance documents and noted that they could easily navigate to specific policy documents they were looking for.

Staff assessed patients’ care and treatment during their stay and delivered care mostly in line with national guidelines. The CCU, for example, met most of the requirements of the key National Institute of Health and Care Excellence (NICE) guidance appropriate to critical care units. These were NICE 83: Rehabilitation after a critical illness, and NICE 50: Acutely ill patients in hospital. The CCU had reviewed itself against these standards and most elements were being met.

The ward did not meet an element of NICE 83 in relation to rehabilitation post discharge from the ward or hospital. This was in the area of providing patients with a structured and supported self-directed rehabilitation manual for use for at least six weeks after discharge from critical care (recommendation 1.1.18). In line with NICE 83 there was, however, a well-established nurse-led follow-up clinic for patients, although this was not being funded. This determined if patients needed further input after two to three months (recommendation 1.1.25).
The provision of rehabilitation did not meet best-practice guidance at all times. Due to a shortage of physiotherapist staff not all patients received a rehabilitation assessment within 24 hours. This initial assessment was often carried out by the medical staff and not a physiotherapist. Patients were not always receiving 45 minutes of each relevant active therapy each day for a minimum of five days per week. This was a recommendation of the Faculty of Intensive Care Medicine (FICM) Core Standard 1.3.4 to enable patients to meet their rehabilitation goals for as long as they were continuing to benefit from the therapy and able to tolerate it. This was derived from NICE guidance around caring for stroke patients and the benefit of rehabilitation. The trust were continuing to recruit physiotherapists in order to address this.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover documents we showed evidenced nursing staff considered the patient holistically and had referred to the patient’s mood and whether they had received visitors.

### 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. A dietician attended the CCU on weekdays to support those patients with naso-gastric tubes, total parenteral nutrition (TPN) feeding (nutrients supplied intravenously through a central line), and Percutaneous Endoscopic Gastronomy (PEG) feeds. PEG is a procedure in which a tube (PEG tube) is passed into a patient’s stomach through the abdominal wall, to provide a means of feeding when oral intake is not adequate TPN was kept in stock on the ward (in plain form) for use when required and the protocol was to commence feeding as soon as possible. Generally, dietician input was as and when requested from staff on the ward.

Where appropriate, patients could access fresh water or drinks at their bed. Nursing staff regularly replaced and refreshed drinks.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. The patient records we reviewed in the CCU were fully completed. Hourly fluid intake and output was measured, recorded and analysed for the appropriate balance. Nursing staff recorded the method of nutritional intake each day. Any required feeding through tubes or intravenous lines (enteral or parenteral feeding) was prescribed and recorded.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the malnutrition universal screening tool (MUST) for all patients on the ward at the time of admission and these were visible in all the medical records we reviewed.

### 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 had access to an acute pain team. This included support from a consultant and nurse qualified in specialist pain management. The pain team were available during normal working hours for advice and guidance. Out of hours, the anaesthetists on duty could provide specialist
pain advice and treatment. Staff discussed patients’ pain management as part of the twice daily ward round.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used appropriate tools to assess pain levels in no verbal patients and those living with dementia or learning disabilities. For example, observation of movement or facial expressions or through physiological monitoring systems or the Abbey Pain Scale tool. Following the administration of pain relief, nursing staff monitored changes in the patients’ behaviour and recorded these to determine effectiveness of the pain relief.

Patients received pain relief soon after it was identified they needed it or they requested it. Patients we spoke with told us staff were always asking if they had any pain and that they were given pain relief as soon as they requested it.

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records we reviewed showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day and additional medicines for break through pain.

**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 well in national clinical outcome audits and managers use the results to improve services further. The service was a longstanding participant in the Intensive Care National Audit Research Centre (ICNARC), improving quality programme (IQP) and getting it right first time (GIRFT) audit programme.

**ICNARC Participation**

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

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

**ICNARC results**

**James Paget Hospital**

The table below summarises the performance for the Intensive/High Dependency Unit at James Paget 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>
</table>

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<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
<th>Range</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non clinical transfers</td>
<td>0.0%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>(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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion</td>
<td>1.7%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Discharge out-of-hours is associated with increased risk of mortality)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)</td>
<td>5.3%</td>
<td>Not in the worst 5% of units</td>
<td>Did not meet</td>
</tr>
<tr>
<td>(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients)</td>
<td>1.1</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
<tr>
<td>(Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We requested an action plan from the trust in relation to audit findings for 1 April 2018 to 31 March 2019. The trust response was “We are performing as expected with our ICNARC quality indicator dashboard within two standard deviations as part as business as usual. Therefore, we do not have an action plan in place and continue to participate in the case mix programme”.

Managers carried out a comprehensive audit programme. Staff participated in the making a difference audit (MAD) programme. This was a six month rolling audit rota which looked at pressure ulcers, central lines, patient records and wound care, among many other things.

Managers shared and made sure staff understood information from the audits. Service leaders shared audit findings at monthly governance meetings. Clinical governance and mortality and morbidity meeting minutes (July 2019) evidenced service leaders discussed audit outcomes. Meeting minutes were shared with the nurse in charge who in turn shared the information with staff at each shift change.

Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. Hand hygiene audit data from June 2019 showed 82% compliance. Managers acted on findings and reminded all medical staff to remove wrist watches and nursing staff of the need to remove personal protective equipment (PPE) such as aprons, at the patient bedside. The hand hygiene audit of July 2019 showed improved compliance of 100%.
The service had a lower than expected risk of readmission for non-elective care than the England average. Quality and activity data showed, from April 2019 to August 2019, only five patients were readmitted to the critical care ward within 48 of discharge to another ward. Readmissions can indicate a patient was discharged too early.

**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. There was an experienced nursing team in the CCU in line with the FICM Core Standards, but the requirement for post-registration training did not meet recommended levels. As recommended by Core Standard 1.2.8, more than 50% of nursing staff should have a post-registration qualification in critical care nursing. At the time of inspection, the ward had only 39% of nursing staff with a post registration qualification. Senior ward sisters told us how they had increased the number of nursing staff who were undertaking this extra training from one to three per year.

Nursing staff completed the national intensive care competencies and local competencies were ward based and stored electronically by the ward managers.

Managers gave all new staff a full induction tailored to their role before they started work. New staff to the ward received an induction and spent a period of at least six weeks supernumerary with support from a lead educator and the matron.

Staff on the ward had cared for 26 children in the period from April 2018 to April 2019. All CCU staff had safeguarding children level 3 training and all band 6 (B6) nurses had received paediatric immediate life support (PILS).

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. From May 2018 to April 2019, 95.3% of required staff in critical care received an appraisal compared to a trust target of 80%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 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</td>
<td>Individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>appraisal</td>
<td>required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>53</td>
<td>56</td>
<td>94.6%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>64</td>
<td>95.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s 80% target was met for all staff groups, with a completion rate of 94.6% for nursing
staff. The trust did not report any medical staff working in critical care.

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

Qualified nursing staff

As of June 2019, the trust reported that 25 of the 63 nursing staff (39%) had a post registration award in critical care nursing. This did not meet the 50% standard set by the FICM core standards.

(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff were assessed each year through appraisals for their competency, skills, and development. The majority of the nursing, healthcare assistants, and other unit-based staff (non-medical staff) had been given an annual review of their competence and performance.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. There was appropriate support for trainee doctors. The feedback we received from the trainee doctors we spoke with was universally positive. The four we met said they felt valued members of the team and would recommend the hospital for training. The consultants were approachable and provided good supervision and support. There was a training programme for foundation year (FY) trainee doctors led by the clinical lead consultant with presentations by registrars. There was a programme of induction to the CCU for new doctors spread over two to three weeks. Those doctors we met said they had not been asked to work outside of their competencies. They said senior consultants and more experienced registrars were always available and willing to teach and support.

Managers made sure staff received any specialist training for their role. Staff attended one study day per quarter where they received training specific to the ward. Training included scenario training, blood sugar monitoring and governance for example. Ward managers kept an electronic register of attendance.

There were enough clinical educators to support staff learning and development. The ward had 1.64 WTE clinical educators, this was one part time and one full time member of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Senior nurses distributed meeting minutes in the staff areas, in staff pigeon holes and via the nurse in charge shift handovers.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Senior nurses and staff we spoke with told us they were encouraged to develop their skills and knowledge. All the staff we spoke with told us they had found their appraisal useful to their career development.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together, when time and staffing constraints permitted, to benefit patients. They supported each other to provide good care remotely.
Staff did not hold regular multidisciplinary meetings to discuss patients and improve their care. Daily ward rounds were not multidisciplinary. There was no input from physiotherapy or pharmacy. The dietician was able to access patient notes electronically to monitor dietary requirements.

There was not always an adequate level of cover to the ward from the pharmacist team and the cover provided did not fully meet the Faculty of Intensive Care Medicine (FICM) Core Standard 1.4.1. The recommended cover level used for the FICM Core Standard was a consensus of critical care pharmacists, the UK Clinical Pharmacy Association, and the Royal Pharmaceutical Society.

When the ward was full with 12 patients and the levels of care were high, the FICM Core Standard 1.4.1 recommended there be one senior grade (band eight A or above) whole-time equivalent (WTE) pharmacist providing a full service to the ward. There was only one pharmacy technician available to the ward one hour per day four days per week, and they were also providing services elsewhere in the hospital. The pharmacy team provided a routine on-call service to make sure advice was available and provided at all times. The pharmacy service was supported by technicians who managed ward stocks and ensured medicines were regularly checked and a safe level of supply maintained.

The senior pharmacist endeavoured to review every patient on the CCU each day, but new admissions could wait several days to be seen. If a patient arrived late on a Friday, for example, the review may not take place until the following Tuesday. The lead pharmacist was not able to attend a multi-disciplinary ward round each day, as this had been deemed as not an effective use of their limited time. They therefore endeavoured to attend one each week or when they were specifically asked to attend. This therefore did not meet the guidance of the FICM Core Standard 1.4.5. The microbiologist attended the unit for one hour per day to monitor those patients who were receiving antibiotic therapy.

There was a shortfall in the service from the physiotherapist team to the CCU due to insufficient staffing levels coupled with the team having a wide-range of other responsibilities within the hospital. There was dedicated physiotherapist support, but this did not meet the recommendations of the FICM Core Standard 1.3.7. Critical care units were recommended to have one physiotherapist for every four beds. When the ward was full (12 beds), the department would need three physiotherapists. There were 3.76 whole-time equivalent physiotherapists working on the ward, but they also had responsibilities for cardiology and respiratory medicine, three surgical wards, and cardiac rehabilitation among others. The team looked to come to the CCU twice each day, but this depended on the pressures elsewhere in the hospital. The physiotherapists did not attend MDT meetings.

Senior wards staff described how they were mitigating the risks by upskilling the bedside nurses to complete basic physiotherapy exercises with their patients under the guidance of the physiotherapist. None of the patient record we reviewed evidenced this had been done. We were not assured patients were receiving the appropriate level of physiotherapy.

Four patient medical records we reviewed showed patients had received one session of physiotherapy delivered by a physiotherapist. One patient had received one visit from a physiotherapist in 12 days. We did not see any evidence of nursing staff completing physiotherapy with any patients.

Dietician and speech and language therapy (SALTs) support was available to the ward on weekdays. The dietician visited the CCU to see all patients twice a week and would visit at other times when requested. The provision of dietetics services was difficult due to a lack of staff. An emergency parenteral nutrition protocol had been produced for staff to use on the weekends or
out-of-hours should a naso-gastric regime need to be commenced and a dietician was not on site. Speech and language therapists did not attend the ward unless requested but were always available if needed for a patient review.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. (AMSAT) Staff referred patients who had presented with mental health issues to the mental health liaison service once they were medically fit or sooner if their behaviour was giving cause for concern.

**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 seven days a week. At the time of inspection, the critical care outreach team (CCORT) was not a seven-day service. The trust was working towards implementing a twenty-four-hour seven day a week service from October.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. A consultant intensivist was available in person at the CCU or on call seven days each week, and to lead the two ward rounds every day. When they were not on duty in the ward, there was good cover from the consultant intensivist team. Consultants lived within a 30 minute journey of the ward when they were at home but on call or would otherwise be resident in the hospital.

During weekdays, the pharmacist team were available on the hospital site in the day time. The service was available on site on weekends and public holidays from 10am to 2pm and then on-call out of these hours. Arrangements were in place for the supply of medicines when the pharmacy was closed. The pharmacist team worked to ensure those medicines used regularly or infrequently, but needed for a complex patient, were available for supply out of hours. A pharmacist was also available on call in the evenings, at night and on weekends.

Access to clinical investigation services was available seven days of the week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT) scans and pathology.

**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 ward. We saw information leaflet on topics such as, smoking cessation, reduction of alcohol intake, reducing deep vein thrombosis risk and fall reduction advice as well as avoiding pressure ulcers.

Information on the menu card helped patients and their relatives to choose a healthy and balanced diet.

Staff displayed posters on the ward around ending pyjama (PJ) paralysis. Staff encouraged patients to dress and sit out where appropriate in a bid to end PJ paralysis. PJ paralysis is a term used to describe the negative physical and psychological effects experienced by patients who spend lengthy periods of time inactive, and in their pyjamas while in hospital.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients had access to smoking cessation support through their
clinical teams. The service was provided by outside organisation with the sustainability and transformation partnership.

**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 appropriately although this was not always documented appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All the staff we spoke with had an appropriate understanding of mental capacity. Ward managers had undertaken an audit of MCA understanding (August 2019) which demonstrated 98% compliance.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained verbal consent from patients where possible when delivering personal care and medications.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. If patients were unable to consent due to sedation, then treatment was provided based on a best interests decision. Staff recorded this in the patients' medical record.

Nursing staff obtained verbal consent from patients, where appropriate, when delivering care. Two nursing staff described how they would liaise with medical staff to obtain a best interest decision if a patient was withholding consent.

Staff clearly recorded consent in the patients’ records. Staff had recorded patients consent to treatment where appropriate in the medical records we reviewed.

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

**Trust level**

The trust advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust set a target of 90% for completion of MCA/DoLS training. In critical care the target was met for both adult safeguarding modules incorporating MCA/DoLS training for which qualified nursing staff were eligible.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at trust level for qualified nursing staff in critical care is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

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*Post-inspection Evidence appendix template James Paget University Hospital NHS Foundation Trust*
Safeguarding adults (Level 1)  55  60  91.7%  90%  Yes
Safeguarding adults (Level 2)  54  60  90.0%  90%  Yes

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

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew to access support and advice, if required, from the safeguarding team via the trust wide intranet.

Staff implemented DoL safeguards in line with approved documentation. We reviewed the record of a former patient who had been placed under a DoL safeguard. Staff had held a multidisciplinary team meeting (MDT) involving the mental health team and the safeguarding team, completed the relevant mental capacity assessment and involved the patients’ family. All documentation was detailed, logical and dated.

At the time of inspection, no patients on the ward were subject to a DoL safeguard.

One patient on the ward was subject to physical restraint to prevent them removing nasogastric feeding lines. The patient’s medical record demonstrated nursing staff had held a multidisciplinary team (MDT) meeting including the patient’s family, staff had documented discussions and concerns leading up to the use of restraint however, there was no formal completed mental capacity assessment for the patient. We raised this with the senior sister.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. Individual staff login in details meant it was easy to see who had made each entry into the patient medical record.

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 drew curtains around patients and closed doors or blinds in private rooms when delivering care. There were signs on curtains asking people not to enter when they were closed unless they asked first. Staff spoke in lowered voices to avoid confidential or private information being overheard.

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 told us that when a patient was admitted to the ward they would update families as early as possible. We spoke with one family who told us they had been kept informed about their relative regularly.

Patients said staff treated them well and with kindness. During the inspection we spoke with four relatives and one patient. All of them told us staff were kind and caring.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains, room doors and privacy blinds when providing care to patients. Staff covered an unconscious patient with a sheet in order to protect their dignity.
The unit had organised a password scheme with the relatives of some patients. This meant family members were able to call the unit by telephone and be able to ask questions and receive answers about their loved ones by giving staff their agreed password.

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 described a situation where they had cared for a patient who had learning disabilities and would not allow any care to be provided to them unless their soft toy received the same treatment. Nursing staff described how they made sure the soft toy was treated the same.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients, their family and friends and also staff. The chaplain visited the ward every day to ensure visibility to staff and patients and would also attend when requested to do so.

Staff described a situation where a patient’s partner had been allowed to lay on the bed with them as the patient wanted a hug.

**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 saw a nurse repeatedly reassuring a patient every time their observation monitor alarmed. Telling them “you’re ok, it’s just because your arm moved, do you feel ok?”.

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 critical care unit (CCU) had introduced the use of the patient diary for longer-stay patients. Diaries were usually started when the patient had been admitted on the ward for three days. Staff and visitors were encouraged to write in the diary with non-clinical entries. Once the patient was discharged they took the diary with them to help them understand the gaps in their memory.

Staff signposted patients and their families to the Louise Hamilton Centre on site. This was a palliative care facility which provided patients and families with bereavement support, carer support, complementary therapies, counselling and specialist welfare advice.

Staff encouraged families and patients to bring in home comforts. One patient was covered with their own fleece blanket. Families had displayed photos of home in the patient’s bed space.

Staff described how they allowed patients to keep their mobile phones with them to enable them to maintain contact with friend and family.

Staff described an occasion where they supported a patient and their family who were all wheelchair bound to go outside. Staff allowed pets on to the unit at the request of patients.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff described how they would support patients and close room doors and curtains around bays if patients became distressed. We did not see any distressed patients during our inspection.

**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. Nursing staff explained what they were doing while treating an unconscious man, used the patients name to address them and apologised for any pain the procedure may be causing.

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. The service had developed its own specific friends and family feedback survey. Staff collated results on a two-monthly basis and displayed them throughout the ward.

The feedback from the survey was positive for the ward. In June and July 2019, the service received 11 responses giving a response rate of 21% and an overall satisfaction score of 78%. We also read cards and letters sent to the ward and comments from the patients and their relatives which included “lovely staff”, “fantastic care”, “wonderful”, “respectful”, “dignified”.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff took time to speak with patients and their families. Families told us they had enough information and that they had been given time to ask questions if there were things they had not understood.

Staff supported patients to make advanced decisions about their care. The trust had a learning disability (LD) lead nurse. Staff told us the LD lead nurse would attend the ward to help them to support patients who had learning disabilities to make advanced decisions about their care.

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.

Managers planned and organised services, so they met the needs of the local population. The ward was located within the hospital to enable staff to respond to emergencies either within the wards or in other related areas such as the operating theatres and emergency department quickly.

Clinical leaders planned to have two beds available per day for elective post-operative patients. Senior nurses told us they avoided cancelling these patients where possible. Data provided by the trust showed from April 2019 to August 2019, the service had cancelled three elective admissions.

Consultants assessed patients in the emergency department or on the ward before admitting them to the critical care ward. This ensured patients received the most appropriate care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff knew that patients who were deemed medically fit for discharge needed to leave the critical care ward within four hours. Staff told us this was not always achievable due to the lack of beds available in the hospital.

Facilities and premises were appropriate for the services being delivered. The ward conformed to the Department of Health guidelines for critical care facilities (Health Building Note 04-02). The bed spaces were of a suitable size, allowing enough space for up to five staff to work safely with a patient in an emergency.
There were two specialist patient isolation rooms to minimise infection cross-contamination with air change facilities and changing lobbies for staff and visitors. These were located at the far end of the ward and could be accessed if necessary without entering the main part of the ward.

There were eight single-rooms in total which meant a high number of patients could receive care in isolation and/or privacy.

There were facilities for patients who were well enough to have a shower or use a toilet.

There were separate entrances to the ward from within the hospital corridors ensuring visitors did not observe patients arriving and leaving the ward. There was intercom-controlled entry to all entrances with closed circuit television (CCTV) in use. Entrances were locked and could only be opened by authorised hospital staff.

The ward had facilities for family members to stay on the ward to be close to relatives.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. However, this was not the case for learning disabilities and dementia. Staff could contact the trust wide mental health team for support and advice if required twenty 24 hours per day seven days per week. The trust also had a learning disability lead nurse and a dementia nurse although they were not available as a 24 seven service.

**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 had a trolley of items which they could use to decorate a bed space if they were expecting the arrival of a child onto the ward. For example, colourful wall stickers.

The service had information leaflets available, however, they were only in English. An information sheet for parents and carers printed by the (intensive care unit) ICU steps support charity was available in the relative’s room. This leaflet provided information on looking after children who had a relative in the ward.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. The trust had a dementia support team which was led by a band seven specialist nurse with two further staff. The team completed patient assessments and provided support and advice to patients and staff.

Staff had access to the trust wide More About Me booklets and to the hospital Passport, however, there were no patients on the wards using these at the time of inspection.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had a full-time learning disabilities specialist nurse to provide additional support to patients living with learning disabilities and staff.

The dementia and learning disabilities professional staff, facilitated reasonable adjustments for people with individual needs, in line with ‘protected characteristics’.

In March 2019, the trust started a mental health programme aimed at improving pathways of care for patients with mental health conditions who were using services, staff safety and patient experience.
Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation service through a third-party provider. Staff could request face to face translators for patients whose first language was not English or British sign language. The trust also had access to telephone translation service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Information provided by the trust website stated “We have 12 different types of menus, covering most dietary requirements. However, for patients with an unusual diet or specific dietary needs we will meet with one of the dieticians and a menu is created for them”.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to picture charts and pain assessment tools to enable, those patients who communicated non-verbally, to take some part in their care.

**Access and flow**

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Staff monitored the time taken to admit a patient to the ward once the decision to admit had been made. The national standard time is less than four hours, the ward aimed to admit all patients within one hour and reported themselves as delayed admittance if it was more than three hours. All the patients’ medical records we reviewed showed patients were admitted within one hour.

Once patients had been admitted to the ward they were seen by a consultant within one hour. This was in line with national guidance.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Quality and activity data (April 2019 to August 2019) showed the service reported three admissions delayed by more than one hour but less than four hours and zero admissions delayed by more than four hours out of 258 patients admitted to the ward.

**Bed occupancy**

From April 2018 to March 2019, James Paget University Hospitals NHS Foundation Trust’s adult bed occupancy was below the England average for 10 out of 12 months.

**Adult critical care Bed occupancy rates, James Paget University Hospitals NHS Foundation Trust.**

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)

Delayed discharges

Managers monitored the number of delayed discharges and took action to prevent them. Quality and activity data showed, from April 2019 to August 2019, 258 patients were admitted to the ward. Of these, 85 (32%) of discharges were delayed by more than four hours but less than 24 hours. 44 patients, (17%) were delayed more than 24 hours. Senior sisters described difficulties in discharges due to blockages in other wards of the hospital.

Non-clinical transfers

The service moved patients only when there was a clear medical reason or in their best interest. Quality and activity data showed, from April 2019 to August 2019, 258 patients were admitted to the ward. There were zero nonclinical transfers.

Non-delayed out of hours discharges to the ward

Staff did not regularly move patients between wards at night. Quality and activity data showed, from April 2019 to August 2019 the number of discharges to ward from 10pm to 7am was 12 patients. Discharge from intensive care from 10pm to 7am can be a surrogate for premature discharge. Premature discharge from critical care to other wards is associated with a significant increased risk of death. Discharge overnight has also been highlighted as an event which impacts adversely on patients' experience.

Quality and activity data showed, from April 2019 to August 2019, only five patients were readmitted to the critical care ward within 48 of discharge to another ward. Readmissions can indicate a patient was discharged too early.

Managers worked to keep the number of cancelled elective patients to a minimum. Data provided by the trust showed from April 2019 to August 2019, the service had cancelled only three elective admissions.

Managers and staff worked to make sure that they started discharge planning as early as possible. For elective patients, for example, those being admitted to the ward post operatively, discharge planning started on admission. For emergency patients, nurses told us discharge planning started once patients were medically fit.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Nursing staff from the ward and critical care outreach staff escorted patients to the stepdown ward when they were being discharged from critical care. Nursing staff completed a discharge pack to accompany the patient, this included NEWS scores and prescription records as well as a copy of the patient medical record. Nursing staff completed a face to face handover to the receiving nurse on the stepdown ward. Critical care outreach team nurses monitored the patient on the new ward.

Staff supported patients when they were referred or transferred between services. Patients discharged from the CCU were reviewed by the critical care outreach team. The outreach team was a nurse-led hospital-ide service involving critical care nurses who provided support, guidance and teaching at the bedside. They would attend patients who were judged as deteriorating on the wards and patients recently discharged from critical care. The outreach team reviewed the latest records for those patients being planned for discharge from the CCU. These patients were then visited by an outreach nurse once they had settled into the new ward.
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. Relatives and patients, we spoke with knew how to raise a complaint or concern although all of them said they had no reason to do so.

The service clearly displayed information about how to raise a concern in patient areas. Staff displayed the patient advice and liaison service (PALS) leaflets in the family rooms. The leaflets described how to make a complaint.

Managers investigated complaints, shared feedback from complaints with staff and learning was used to improve the service. The ward had previously received complaints about noise levels. The hospital had invested in technology which looked like an ear and displayed green when noise levels were acceptable, amber when they were increasing and flashed red when noise levels were too high. The hospital had also relocated printers away from bed spaces, changed the bins, doors and trolleys to reduce noise. This demonstrated acting on complaints.

Trust level

From June 2018 to May 2019 the trust received one complaint in relation to critical care (0.4% of the total complaints received by the trust). The subject of this complaint was communications.

The trust took 29.0 working days to investigate and close this complaint. This is in line with their complaints policy, which states complaints should be closed within 60 working days.

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

From May 2018 to April 2019 there were three compliments received for critical care (0.4% of all compliments received trust wide).

Compliments were received in two of the 12 months of this period. Two compliments were received in July 2018 and one was received in October 2018.

The trust did not provide a breakdown of the compliments received by subject.

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

Is the service well-led?

Leadership
Leaders had the integrity, 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.

The critical care service was part of the elective division and was led by a clinical lead consultant intensivist and a band 8 (B8) senior nurse who reported to the divisional leaders. The clinical lead and the senior nurse both had extensive experience in the critical care setting and had undertaken appropriate leadership training and development courses.

The service had an identifiable clinical director for critical care as well as an identifiable nurse lead (B8) and identifiable supernumerary clinical coordinator on every shift (B7).

Two band seven (B7) senior sisters oversaw the day to day running of the critical care ward in a supernumerary clinical coordinator capacity. A daily nurse in charge was also supernumerary and not rostered to deliver direct patient care.

All the staff we spoke to from all staff grades spoke positively about the approachability and visibility of the local service leaders.

Vision and strategy

The service had a vision for what it wanted to achieve but no documented strategy. Leaders and staff understood the trust wide values and felt staff lived by them.

Service leaders had a vision to remove doors from private rooms in order to increase patient visibility and safety.

The trust values were; courtesy and respect; attentively kind and helpful; responsive communication; effective and professional. All the staff we spoke with knew the trust values and said they felt people lived by them. Staff described how their annual appraisal aligned to the trust values.

Culture

Staff felt respected, supported and valued. The service promoted and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All the staff we spoke with were positive about the culture on the ward, staff told us they felt happy to raise concerns. Staff of all grades spoke to each other respectfully.

The trust participated in the NHS staff survey. The last staff survey conducted in 2018/19 showed an improvement in the measure of the percentage of staff believing that the organisation provided equal opportunities for career progression or promotion. The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months had improved with 22.1% reporting bullying and harassment compared to 27% on the previous year.

The service had mechanisms for providing all staff at every level with the development they needed, for example, the progression from health care assistant (HCA) to registered nurse (RN) and from band 5 (B5) nurses to band 6 (B6) nurses. Posters displayed in staff areas promoted staff to apply, to attend additional training courses.
None of the staff we spoke with were aware of the trust’s freedom to speak up guardian (FTSUG). Freedom to speak up guardians are employed across all NHS trusts to offer guidance and support to staff, contractors, volunteers and students.

**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.**

All levels of governance and management function effectively with each other. The divisional operations manager attended the monthly governance meetings and escalated information to and from the divisional meeting.

The service leaders had improved the governance process as a result of feedback from our last inspection (2015). Service leads held monthly governance meetings which followed a set agenda and were minuted. We observed a monthly governance meeting (4 September 2019). The meeting was well attended by the divisional manager, service leaders and staff of appropriate grades.

Senior ward sisters held monthly senior nurse governance meetings with the lead nurse to share information from the monthly governance meeting and review dashboards.

The nurse in charge also shared information with the staff on the ward at each shift handover via the seven-day handover. Managers shared meeting minutes leaving a copy in staff pigeon holes, by newsletter and a hard copy in the staff rest room.

**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.**

Meeting minutes dated 31 July 2019, demonstrated service leaders discussed risks of the service during the monthly clinical governance and mortality and morbidity meetings.

Senior nurses described the risks faced by the service, for example, nurse staffing, physiotherapy and pharmacy support and the mitigating action service leaders had taken to reduce them. These were the same risks as were recorded on the provider wide risk register.

The service not meeting the standard for the number of nursing staff holding an intensive care qualification and an information technology concern were recorded on the local risk register for critical care. Senior nurses on the ward described the risk and the ongoing mitigating actions.

The service participated in national audit schemes to enable managers to monitor the performance of the service and improve on it.

**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.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels. Staff had sufficient access to relevant information. All appropriate staff had a unique electronic secure log in to access patient records or information stored on the trust wide intranet.

Service leaders used key performance indicators (KPI) as clear and robust service performance measures. KPI were reported, monitored and discussed as part of monthly governance meetings and at senior sisters’ meetings.

Managers were confident the data they collected was accurate as it was electronic and did not involve transcription which introduced data errors. This meant the data they used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant.

The service used information technology systems effectively to monitor and improve the quality of care. The bedside automated patient monitoring system collected data relating to the patient’s vital signs every 15 minutes. Nursing staff validated this data in line with the timeframe agreed in the patient’s care plan.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

Staff gave patients a feedback questionnaire with a self-addressed envelope as part of their discharge pack in order to collect their feedback.

Staff gave examples of where changes had been implemented across the service as a result of “you said we did”. For example, relatives had reported the family room was “stuffy” so the service had bought some fans for families to use if the room became too warm.

Patients had asked for paper cup use to be reduced so the ward staff had introduced mugs for all staff and patients.

Staff had acted on feedback from patients at the follow up clinics regarding difficulty in sleeping while on the ward. The service had purchased a sounds machine which played bird sounds, among others, and was used to address sleep disturbance and delirium for patients on the ward.

Senior nursing staff encouraged staff to make suggestions of service improvement. Staff had suggested introducing a “preferred name” section on the patient information board. White boards in patient bed areas had the patient’s preferred name recorded. Staff told us this was helpful when they were caring for different patients.

Medical staff held a three-monthly drop-in session. Staff of all grades were invited to come and have tea and cake and an informal discussion about the service and any issues.

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.
Three staff were attending the post registration qualification course. This would mean that 44% of staff on the unit held the qualification. While not in line with FICM core standards (50%), it was an improvement on the current situation.

The service had recently introduced a band six (B6) nurse development post to aid in staff retention. The post involved a B5 nurse being supported as a B6 nurse for a year enabling them to have the confidence to develop into a B6 nurse.

The service had introduced the technique of applying glue to the site of removal of arterial lines to prevent air embolism developing. This technique had now been included in national guidelines.

### Services for children and young people

#### Facts and data about this service

The neonatal, children’s and young people’s service consists of:

- **The neonatal service**: The neonatal unit provides care for premature and sick babies over 30 weeks gestation. Babies who are born before 30 weeks gestation or require ventilation for over 24 hours will be stabilised before transferring to a bigger neonatal unit which can provide ongoing intensive care. On the neonatal unit the trust provides care for short term ventilation, non-invasive ventilation and oxygen therapy. The trust manages all medical conditions including infections, babies who need phototherapy for jaundice, who need assistance with feeding through a gastric tube, or for babies who need help with temperature control.

- **Children and young person’s ward**: Provides surgical and medical care from new-borns through to the 19th birthday. Ward 10 is split into two further areas, 10a and 10b. Ward 10a is the medical paediatric ward which includes a six bedded bay, four side rooms, two high dependency rooms and a paediatric assessment unit. Ward 10b is the surgical paediatric ward with eight beds as well as the six bedded young person's unit. This consists of three single same sex rooms with en-suite facilities for two as well as a sitting room. The trust provides overnight accommodation for parents to stay with their children as well as a parents' kitchen and sitting room.

- **The Cove**: Provides outpatient services for children and young people, including pre-assessment for booked surgery. From birth to transition to adult care, the service is provided at the James Paget University Hospital in a dedicated children’s clinic area. There is a range of specialties within the department, as well as visiting consultants from other hospitals for tertiary speciality outreach clinics.

- **Children’s community nursing team (CCNT)**: This is a six day a week service seeing children and families in their own home, schools, colleges or nurseries. The trust will see children from birth to their 19th birthday with a nursing need; this includes any child with complex medical and nursing needs. The CCNT offers training to children and their families as well as teachers, carers and other medical or nursing staff. They generate and update school health care plans allowing children with medical and nursing needs to attend school. Within CCNT there is a respite service which offers children and families with long term health needs a carer who will...
be trained to support the family in their own home. CCNT also has a number of nurse specialists available in diabetes, healthy weight, enuresis, epilepsy and allergy along with clinical nurses based in two local special schools, working closely with the relevant families and multidisciplinary team.

- **Paediatric recovery**: Designated paediatric recovery separate from the main adult recovery where children can be nursed in a child friendly environment by equipped paediatric trained staff.

- **Community paediatrics**: Newbury clinic (a satellite site) provides general community paediatric assessment and diagnosis of children with possible neuro muscular conditions (for example cerebral palsy), genetic conditions, developmental delay and neurodevelopmental disorders (such as autistic spectrum disorder and attention deficit hyperactivity disorder). The service is involved in a wide range of multi-disciplinary and multi-agency team collaborations including working closely with other departments within and outside of the trust, such as a local mental health trust, physiotherapist, occupational therapists and speech and language therapists.

- **Paediatric therapies**: Provide a physiotherapy assessment and treatment service for children and young people up to the age of 12 years old and up to the 18th birthday for children and young people in special schools and a specialist paediatric orthopaedic clinic. The service also provides a paediatric occupational therapy assessment service for children and young people up to 18 years. There are bespoke paediatric dietetic clinics. The dietitians also provide support to the inpatient service, CCNT and specialist outpatient clinics.

(Source: Acute Routine Provider Information Request – Context acute tab)

The trust had 3,017 spells from February 2018 to January 2019.

Emergency spells accounted for 81% (2,450 spells), 12% (373 spells) were day case spells, and the remaining 6% (194 spells) were elective.

**Percentage of spells in children’s services by type of appointment and site, from February 2018 to January 2019, James Paget University Hospitals NHS Foundation Trust**
(Source: Hospital Episode statistics)

During the inspection we visited the neonatal unit, the children’s outpatient department and ward 10a and 10b. We also visited the surgical theatres and radiology. We visited the Newberry clinic and attended one community patient visit. We spoke with 30 members of staff, including medical staff, nursing staff, nursery nurses, play specialists, managers and other members of the multidisciplinary team. We spoke to nine parents and three children. We reviewed eight care records for children and young people and nine prescription charts throughout the inspection.

**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.

Nursing staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from May 2018 to April 2019 at trust level for qualified nursing staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire safety 1 year</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>57</td>
<td>57</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>63</td>
<td>66</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>63</td>
<td>66</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>63</td>
<td>66</td>
<td>95.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical gases</td>
<td>50</td>
<td>53</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>61</td>
<td>66</td>
<td>92.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>61</td>
<td>66</td>
<td>92.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>59</td>
<td>66</td>
<td>89.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In services for children and young people the trust had an overall mandatory training compliance rate of 95.3% for qualified nursing staff. The 90% target was met for 11 of the 14 mandatory training modules for which qualified nursing staff were eligible, and almost met for the remaining three mandatory training modules.

Medical staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from May 2018 to April 2019 at trust level for medical staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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>18</td>
<td>18</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety for managers</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety 1 year</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>16</td>
<td>18</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people the trust had an overall mandatory training compliance rate of 91.4% for medical staff. The 90% target was met for six of the 10 mandatory training modules for which medical staff were eligible, and almost met for a further three mandatory training modules.

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

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff told us that some of the mandatory training required face to face attendance and some of the training was completed in work books.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Staff told us that they had completed this training; they told us that additional external training was available for them to attend. For example, the local children’s mental health unit provided training sessions on children’s mental health which staff on the paediatric ward told us they had accessed.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had central oversight of mandatory training, however it was managed by ward coordinators locally. Ward coordinators booked training for staff members and emailed them reminders.

Safeguarding
Staff understood how to protect children, young people and their families 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.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for qualified nursing staff in services for children and young people is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>65</td>
<td>66</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>64</td>
<td>66</td>
<td>97.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>62</td>
<td>65</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – 3 Yearly</td>
<td>59</td>
<td>66</td>
<td>89.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people the trust had an overall safeguarding training compliance rate of 94.7% for qualified nursing staff. The 90% target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible, and almost met for the remaining training module.

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

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for medical staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>17</td>
<td>18</td>
<td>94.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – Annual</td>
<td>15</td>
<td>18</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>14</td>
<td>17</td>
<td>82.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In services for children and young people the trust had an overall safeguarding training compliance rate of 92.5% for medical staff. The 90% target was met for four of the six safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Clinical staff working directly with children completed level three safeguarding training. This was in line with the intercollegiate document Safeguarding Children and Young People: Roles and competencies for Health Care Staff, originally published in March 2014. Staff told us that safeguarding training also included the subject of female genital mutilation and child sexual exploitation.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff provided examples where they had raised safeguarding concerns about children and their families. For example staff told us they had raised concerns they had about possible neglect.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff throughout the service demonstrated a good understanding of safeguarding risks. Staff described a positive working relationship with the safeguarding leads within the trust, who in turn, liaised with other agencies if necessary. Some staff members informed us that they had attended safeguarding strategy meetings within the trust alongside other agencies. This is where staff from different agencies work together to plan care for children at risk or with an identified risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were clear about the trust’s process for making safeguarding referrals. All staff we spoke to knew who the trust’s children’s safeguarding lead was and told us the lead supported them to make safeguarding referrals if required.

Staff followed safe procedures for children visiting the ward. The paediatric ward, neonatal unit and paediatric emergency department were secured and accessed by staff electronic passes. Staff had access to safeguarding information via an electronic system which alerted staff to children who were subject to a child protection plan.

**Cleanliness, infection control and hygiene**

*The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, 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 well-maintained. All waiting and clinical areas we inspected were visibly clean. Sharps bins were labelled and not overfilled. Ward areas contained side rooms which were used for babies, children and young people who needed to be kept in isolation due to infection, or to avoid getting an infection if their immune system was compromised.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Play specialist staff in ward 10 maintained a rota for cleaning toys which we reviewed, which was signed daily since 1 January 2019. The toys were stored in plastic containers which were labelled with the date the contents were last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff washing their hands upon entrance to the neonatal ward and using hand sanitiser on ward 10. We observed staff washing their hands before and after patient contact, and
they adhered to the ‘bare below the elbow’ policy. PPE was readily available, and we observed staff using PPE when appropriate.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff labelled equipment with ‘I am clean’ stickers after cleaning which showed the last date it was cleaned. We observed staff carrying out a thorough clean of an incubator on the neonatal unit during our inspection.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 9.0 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Environment and equipment**

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

Children, young people and their families could reach call bells and staff responded quickly when called. All children, young people and families we spoke with told us staff responded promptly when they needed their attention.

The design of the environment followed national guidance. Ward 10, the neonatal unit and the paediatric recovery areas were accessed via staff swipe cards or an intercom system in order to protect patients and help minimise the risk of absconding.

Ward 10 had a separate area for adolescent patients. There were three rooms that had two beds and en-suite facilities to be used by adolescents. There was also a designated room for adolescents to use which included a television, age appropriate books and games. The children’s outpatient clinic was used by children and young people only. There were separate waiting areas for younger and older children. The children’s recovery area in theatres was separate from the adult areas; children and their families left the recovery area without coming into contact with adults.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment checks had taken place on a daily and weekly basis, in line with the trust policy. We saw that resuscitation trolleys were ‘tagged’ to ensure staff could detect if they had been tampered with, all items were well organised, clean and with sealed packaging. All equipment and the corresponding expiry dates were listed in the checklist folders.

The service had suitable facilities to meet the needs of children and young peoples’ families. The service supplied pull out beds which provided parents and carers the opportunity to stay with their child overnight. There was a parents’ kitchen on ward 10 which parents used to make themselves drinks.

The fridge on the neonatal unit was unlocked. The fridge contained expressed milk and we raised this with the trust as a safety issue. Following our inspection, the trust provided information to state they had reviewed national guidance and recommendations on the subject. The service planned to develop a solution in collaboration with clinicians and parents that would ensure safe storage and independent access for parents to their milk.
The service had enough suitable equipment to help them to safely care for children and young people. Staff reported that they had no concerns with access to equipment. The servicing of equipment was managed by the estates team. We reviewed the service’s equipment servicing data. Out of 131 items, there were three items that were recently out of date for their service. These items were highlighted to signify that the estates team were aware. Five items were missing so it had not been possible to maintain their service dates.

Staff disposed of clinical waste safely. Staff had access to appropriate clinical waste bins and disposed of the waste using the correct bins for the different waste products.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. A paediatric early warning score (PEWS) tool was used to monitor and manage deteriorating patients on ward 10 and a neonatal alert, trigger and track (NATT) escalation aid was used to monitor and manage deteriorating babies within the neonatal unit. The PEWS was adapted depending on the age of the child and we saw examples of these having been completed. All those we reviewed were fully completed and scored correctly with any concerns escalated appropriately.

Staff completed risk assessments for each child and young person on admission / arrival and updated them when necessary and used recognised tools. All children and young people had an admission form completed which was filed in their individual patient records. Staff used a Sepsis six care bundle, based on National Institute for Health and Care Excellence (NICE) guidance, for the management of patients with presumed or confirmed sepsis. A sepsis assessment was included on the front of all admission forms to ensure staff completed them.

Staff knew about and dealt with any specific risks to the service. Staff had access to an electronic system which flagged whether children had any protection plans in place or any other relevant social history. This enabled staff to ensure the correct protective measures were in place.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person’s mental health). Staff had access to the local child and adolescent mental health service (CAMHS) seven days per week. Staff could contact CAMHS Monday to Friday between 9am and midnight, and from 9am to 1pm at weekends. There was a link mental health nurse who provided telephone advice to staff and regularly attended the hospital. A standard operating procedure was developed between the trust and CAMHS. This document provided guidance to staff to protect a child or young person with mental health needs.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Staff told us that nursing discharge letters were shared with schools and/or health visitors where appropriate. Discharge letters were shared with GP’s, which health visitors accessed via GP’s if required.

Shift changes and handovers included all necessary key information to keep children and young people safe. Nursing handovers took place at 7am and 7pm. Doctors handovers took place at 9am, 5pm and 9pm. The senior sister for ward 10 and the children’s safeguarding lead attended the doctor’s handover on a Friday morning which included discussion and training around any safeguarding issues. There was a multi-disciplinary handover on ward 10 which was used by all
members of staff. This ensured patient information was shared with all staff to help keep children and young people safe.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 7.9 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 9.5 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 about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

The service was taking action to ensure they had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 was recruiting nursing staff of relevant grades to keep children and young people safe. At the time of our inspection there were five nursing vacancies across the service, however four of those vacancies had been recruited to and were due to join the service shortly. Service leads developed a business case to propose a need for more nurses within the service.

Nurses qualified in specialty (QIS) were registered nurses who had undertaken additional training and competencies to become neonatal nurses. The standard for services to achieve was 70% QIS according to the British Association of Perinatal Medicine (BAPM). The neonatal unit achieved 58% QIS nursing staff. Nurses who were already QIS worked extra bank shifts on the ward to help mitigate staffing risks. The service supported nurses to complete QIS training and nurses would only be placed on the neonatal unit if they were willing to undertake the additional training.

The service had access to a senior children’s nurse for advice at all times during the 24 hour period. This was in line with Royal College of Nursing guidance on defining staffing levels for children and young people’s services.

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 service used a dependency tool to predict their staffing needs.

Trust level

The table below shows a summary of the nursing staffing metrics within services for children and young people at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.
<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>138</td>
<td>8%</td>
<td>11%</td>
<td>2.5%</td>
<td>3,012.0 (3%)</td>
<td>0.0 (0%)</td>
<td>381 (&lt;1%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>59</td>
<td>3%</td>
<td>11%</td>
<td>2.4%</td>
<td>3,012.0 (3%)</td>
<td>0.0 (0%)</td>
<td>381 (&lt;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 were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover. The trust did not report any agency usage for nursing staff in services for children and young people.

The ward managers could adjust staffing levels daily according to the needs of children and young people. Service leaders told us they flexed staff from other areas within services for children and young people to ensure all areas were staffed appropriately. The service had a process for the rotation of staff between ward 10, the paediatric emergency department, the neonatal unit and paediatric recovery. This enabled the service to have staff in areas with the right skill mix and qualifications to ensure appropriate staffing levels were maintained.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. We reviewed staffing rotas during our inspection and found that safe levels of staffing were maintained.

Vacancy rates

There were nurse vacancies within the service, however, the majority of these had already been recruited to. Service leaders sourced staff from other areas within services for children and young people to ensure all areas had sufficient staffing.
Monthly vacancy rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed a shift from November 2018 to April 2019.

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

There were vacancies in the community team for band seven physiotherapists and occupational therapists (OT). The service had tried to recruit; however, this had been unsuccessful. The service made attempts to mitigate this concern, for example, a band five OT had been moved to a band six post to provide support to the OT team.

Sickness rates

The service had a low sickness rate which was lower than the trust target.

Monthly sickness rates from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed an upward trend from June 2018 to October 2018.
Bank staff usage

The service had increased rates of bank nurses used on the wards between November 2018 and March 2019. This reflected nursing vacancies within the service at the time. The service did not use agency staff but used bank staff, who were usually staff from the ward or nursery nurses who were familiar with the ward.

Monthly bank hours from May 2018 to April 2019 for qualified nurses, health visitors and midwives showed an upward trend from November 2018 to March 2019.

Medical staffing

The service was taking action to ensure they had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families 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.

The service was working towards having enough medical staff to keep children and young people safe. The service was addressing their vacancies and were in the process of recruiting to them. Out of hours cover was provided on a rota basis and staff confirmed that this worked well, stating that medical staff were available when needed. The consultants also worked a ‘hot week rota’
system where they were also available out of hours. Consultant cover was available for 24 hours a
day, seven days a week on the neonatal unit and ward 10.

Trust level

The table below shows a summary of the medical staffing metrics within services for children and young people at trust level compared to the trust’s targets, where applicable. Please note that the trust does not have target vacancy or turnover rates.

<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 (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>138</td>
<td>8%</td>
<td>11%</td>
<td>2.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>23</td>
<td>10%</td>
<td>17%</td>
<td>1.1%</td>
<td>2,529 (5%)</td>
<td>0.0 (0%)</td>
<td>661 (1%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The trust confirmed that, at the time of reporting, there was a nurse practitioner vacancy which was covered by a junior doctor and they had been unable to recruit to the one WTE paediatric consultant vacancy.

Medical staffing rates within services for children and young people 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 usage. The trust did not report any locum usage for medical staff in services for children and young people.

Vacancy rates

There were medical staff vacancies within the service, however the trust was addressing these. There was one consultant vacancy, which the trust had difficulty recruiting to. The service leaders converted the post to a registrar post and they identified someone to take up the post who will be due to start next year once they have completed the necessary training.

At the time of our inspection there was a 1.4 whole time equivalent (WTE) registrar vacancy. There was an individual recruited to start by the end of September 2019. Middle grade doctors were at full establishment.
Monthly vacancy rates from May 2018 to April 2019 for medical staff showed a shift from November 2018 to April 2019.

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

Sickness rates for medical staff were low. Sickness for medical staff stood at 1.1% against a trust target of 4%

The service reported no use of locum staff. Service leaders told us they have carried out overseas medical staff recruitment and development for middle grade doctors, which has helped to avoid the use of locum staff.

Staffing skill mix

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

As of 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 about the same as the England average.

Staffing skill mix for the 23 whole time equivalent staff working in services for children and young people at James Paget University Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>42%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
Records

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

Patient records were comprehensive, and all staff accessed them easily. The service used paper based records which contained various information including care plans. We reviewed eight patient records from the neonatal unit and ward 10. Records were accurate, complete and noted multi-disciplinary team involvement with other healthcare professionals where relevant. Risk assessments had been completed where required. For example, paediatric early warning scores (PEWS) and assessments of nutritional status had been completed where applicable in each patient record we reviewed.

The trust audited care records for completion across the service. We reviewed several audits, we observed the audit scores for ward 10 were at 97.9% in December 2018 and lowered to 87.7% in April 2019 and improved to 98.7% in June 2019. Audit results for the neonatal unit were 77.8% in December 2018 but improved to 97.8% in April 2019 and 95.3% in June 2019.

When children and young people transferred to a new team, there were no delays in staff accessing their records. All staff we spoke with told us that they could access the records of children and young people when they needed them. Discharge letters were sent to children’s GPs upon their discharge, to ensure information sharing and continuity of care within the community.

Records were stored securely. We observed patient records stored securely on ward 10 and the neonatal unit to protect patient confidentiality.

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. Medicines were prescribed electronically. We reviewed nine prescription records for children and young people who used the service. In all cases prescriptions were signed and dated, allergies documented, where required antibiotics were prescribed in line with guidelines, writing was legible, and the age and weight was recorded. Medicines were stored in locked cupboards and fridges, in line with the trust’s policy, on ward 10, the neonatal unit and children’s outpatients.

Staff reviewed children and young people’s medicines regularly and provided specific advice to children, young people and their families about their medicines. Pharmacy staff provided support to ward staff and ensured medicines were restocked. Relatives of children and young people told us that staff provided them with information and advice about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We reviewed controlled drugs (CDs) held within the neonatal unit and ward 10. CDs had been checked on a regular basis. All CDs and other medicines were stored securely in lockable cupboards, in line with the trust’s policy.
Staff followed current national practice to check children and young people had the correct medicines. We observed medicines being administered, staff checked the appropriate name and date of birth of the patient before medicines were given.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Staff spoke with told us that doctors held weekly grand rounds. These were meetings that were used to discuss any incidents and any identified learning. Any learning from incidents was also shared via monthly team emails and newsletters.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. There were guidelines for paediatric doses which were used by prescribers and as a reminder for those administering medicines on the wards and in paediatric recovery.

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.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and report them using the trust’s electronic reporting system. There were processes in place for investigating incidents and staff informed us that feedback was shared at a local level by their managers. Following incidents on wards, staff told us that learning from incidents was shared in ward newsletters and at local meetings.

Staff reported all incidents that they should report. Staff could describe the types of incidents that required reporting. The trust held regular mortality and morbidity meetings. From reviewing meeting minutes from June, July and August 2019, we saw learning was identified and shared and actions were put in place. For example, the review of one case identified learning that oxygen saturation should be recorded as part of the newborn early warning trigger and track (NEWTT) score. This was also documented as an action and assigned to an individual.

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 May 2018 to April 2019, the trust reported no never events for services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. Upon reviewing the service’s monthly governance meeting minutes and incident log from May, June and July 2019, it was evident that incidents were reported appropriately.
In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from May 2018 to April 2019.

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

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Obstetric incident: baby only (this include foetus, neonate and infant)</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>HCAI/Infection control incident</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Screening issues</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. The duty of candour is a statutory duty to be open and honest when something goes wrong that appears to have caused or could lead to significant harm in the future. Staff told us that they invited family members to meetings at the hospital to discuss concerns they had raised. We observed the duty of candour was applied where necessary. We reviewed the service’s incident log and found that incidents had been raised appropriately and descriptions were thorough.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that feedback and learning from incidents was regularly shared. For example, we saw an action for a Healthcare Safety Investigation Branch (HSIB) report to be shared among consultants.

Staff met to discuss the feedback and look at improvements to children and young people’s care. Incident logs were updated and included identified learning and how it was shared. Methods for shared learning included updating the lessons learnt board and risk board in the ward area, asking staff to write a reflective account and sharing quality and safety issues with the clinical governance and patient safety group.

There was evidence that changes had been made as a result of feedback. The trust safeguarding leads told us that they reviewed and adapted their training for staff following incidents. They also used specific learning from incidents to provide as examples to staff to aid their learning. The safeguarding leads described an example of how they made specific changes to child protection paperwork to facilitate improved observational descriptions following an incident. They also involved staff in the process of learning from incidents and asked them what could have made situations better.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. The service’s monthly paediatric clinical governance meetings regularly reviewed issues of patient safety. Incidents were documented appropriately to prompt review and identify any possible learning.
Managers debriefed and supported staff after any serious incident. There was a process in place to ensure staff received a debrief following a serious incident. This was facilitated by the trust safeguarding leads where appropriate.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors. Safety thermometer data was displayed on wards for staff, children, young people and their families 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.

The safety thermometer data showed the service for children and young people achieved an average of 88% harm free care for the last 12 months.

Staff used the safety thermometer data to further improve services. It was monitored by the ward sisters.

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from April 2018 to April 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 evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people 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. Trust policies followed national guidance and staff followed them. We reviewed ten policies, including but not limited to sharing bad news with parents and management of sudden infant death syndrome. Eight of these were within date.

The neonatal unit was working towards accreditation to the Baby Life Support Systems (BLISS) baby charter. This meant that the unit aimed to be recognised for providing a high-quality approach to family-centred care. The unit had completed two out of seven principles at the time of our inspection. The completed principles were; ‘every baby should be treated as an individual with dignity, respecting their social, developmental and emotional needs as well as their medical and surgical needs’, and ‘discharge planning is facilitated and co-ordinated from initial admission to discharge date, to ensure both the baby and their family receive the appropriate care and access to resources’.
Managers carried out a comprehensive audit programme. There was a rolling programme of regular audits, however, managers would also undertake responsive audits if required. For example, a paediatric early warning score (PEWS) audit was completed in May and June 2019. Actions were assigned to staff and completed within the given timeframe. Audits were discussed at monthly audit meetings and action plans were in place in order to improve future outcomes.

Managers implemented changes to practice following the outcome of audits to improve care for patients. For example, following an audit of sedation prior to surgery, a new proforma was introduced to ensure correct information was captured and the correct steps had been taken prior to sedation, in order to protect the safety of children and young people whilst being sedated.

We saw evidence-based pain assessment tools being used according to the age and understanding of the child.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff worked in line with a standard operating procedure (SOP) for supporting children and young people who attended the hospital with mental health needs. The SOP referred to relevant legislation such as the Mental Health Act, and guidance on the use of medicines from the British National Formulary (BNF). The SOP was developed in collaboration with the local child and adolescent mental health service (CAMHS). Staff told us they worked closely with the local CAMHS.

**Nutrition and hydration**

Staff gave children, young people and their families 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 children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Children, young people and their families told us that they had enough to eat and drink, and that food choices were suitable.

Staff told us that they developed a more child friendly menu, following feedback about the food options from families.

Staff informed us that the nil by mouth policy had been changed to allow children and young people to have a drink of water when they arrived prior to surgery. Staff reported that it had a positive impact on children and young people and helped them to feel more relaxed.

Staff fully and accurately completed children and young peoples’ fluid and nutrition charts where needed. We observed five children and young people’s fluid and nutritional needs charts were completed.

Specialist support from staff such as speech and language therapists was available for children and young people who needed it. Ward staff had access to a multi-disciplinary team which included speech and language therapists who recorded updates in patient records where appropriate.

**Pain relief**
Staff assessed and monitored children and young people 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 children and young peoples’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. A pain scoring tool based on pictorial faces was used within the service. This was documented in the paediatric early warning scores chart, which we observed from our review of patient records which demonstrated full completion.

Children and young people received pain relief soon after requesting it. All children, young people and their families that we spoke with told us that they received pain relief when it was requested. This was evidenced in the prescription records we reviewed. Staff told us that pain scoring was important to ensure appropriate pain relief was administered at the right dose in a timely manner.

Staff prescribed, administered and recorded pain relief accurately. We reviewed nine prescription records for children and young people and found that these were accurately completed.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.**

The service participated in all relevant national clinical audits. The service mostly performed well in national clinical outcome audits and managers used the results to improve services further. Where national standards were not met, the service performed comparably to other hospitals. The service had action plans in place for the paediatric diabetes audit and the national neonatal audit programme, and monitored their compliance against the actions. Actions from the neonatal audit were assigned to staff. Actions from the paediatric diabetes audit were all complete, however only one action had been assigned to a specific person.

The service received a letter from the Royal College of Paediatrics and Child Health, congratulating them on their outstanding rate of change between the 2016 and 2018 national neonatal audit for the measure ‘is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of a baby’s first admission?’ There was an increase of 20.5% whereas the national rate of change was 1.9%.

The service was participating in the Baby Life Support Systems (BLISS) baby charter. This provided a framework for neonatal units to assess the quality of family-centred care they delivered against a set of core principles. It enabled neonatal units to monitor their practices and develop plans to achieve changes that benefited babies and their families. For example, the neonatal unit had lockers for parents to use in the parent’s rest room.

**Paediatric diabetes audit**

The table below summarises James Paget Hospital’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)</td>
<td>80.4%</td>
<td>Better than expected</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
with Type 1 diabetes that should be
performed at least annually)

<table>
<thead>
<tr>
<th>Case-mix adjusted mean HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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>
</tr>
<tr>
<td>70.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Median HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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>
</tr>
<tr>
<td>66.8</td>
</tr>
</tbody>
</table>

(Source: National Paediatric Diabetes Audit)

Managers used information from the audits to improve care and treatment. They maintained action plans with all recommendations achieved. For example, one recommendation from the national diabetes audit was ‘multidisciplinary paediatric diabetes teams should ensure that screening for thyroid and coeliac disease takes place at diagnosis of type one diabetes.’ Following this action, an audit was commenced in September 2018 to try and improve screening rates to 100%.

There were engagement meetings and/or follow-up of audit outliers. Audit meetings took place within the service to address audit findings and monitor the implementation of action plans. Improvement was checked and monitored within these meetings.

Managers shared and made sure staff understood information from the audits. Managers told us that specific changes to practice following audit results were communicated via email, included in newsletters and at team meetings.

National Neonatal Audit Programme

The table below summarises James Paget Hospital’s performance in the 2018 National Neonatal Audit Programme 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>64.6%</td>
<td>Within expected range</td>
<td>Not met</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</td>
<td>80.2</td>
<td>Negative outlier</td>
<td>Not met</td>
</tr>
</tbody>
</table>
Do all babies < 1501g or a gestational age of < 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)

96.0% Within expected range Not met

Do all babies with a gestation at birth <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)

Suppressed due to low numbers N/A N/A

(Source: National Neonatal Audit Programme)

Paediatric Intensive Care Audit (PICANet)

James Paget University Hospitals NHS Foundation Trust did not participate in this audit.

(Source: PICANet)

Emergency readmission rates within two days of discharge

The data shows that from February 2018 to January 2019 no specialties at James Paget University Hospitals Foundation Trust had six or more emergency readmissions within two days of discharge following an elective admission for either the under one age group or for patients aged one to 17 years old.

The tables below show the percentage of patients (by age group) who were readmitted within two days of discharge following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from February 2018 to January 2019 there was a similar percentage of under ones readmitted following an emergency admission compared to the England average for paediatrics. No other specialty at the trust had six or more readmissions.

For patients aged one to 17 years old, there were lower percentages of patients readmitted following emergency admissions compared to the England averages for paediatrics and general surgery. No other specialty at the trust had six or more readmissions.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>James Paget University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2018 to January 2019)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: PICANet)
Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2018 to January 2019)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>James Paget University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.1%</td>
<td>1,599</td>
</tr>
<tr>
<td>General surgery</td>
<td>2.8%</td>
<td>215</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2018 to February 2019 there were no patients under the age of one who had multiple admissions for asthma at the trust. There were no admissions for diabetes or epilepsy in this age category.

The percentage of patients aged one to 17 years old who had multiple admissions for asthma at the trust was lower than the England average and the rate was higher for epilepsy. There were five or less patients with multiple admissions for diabetes in this age category.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years) (March 2018 to February 2019)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>James Paget University Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>13.8%</td>
<td>87</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>27</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>38.1%</td>
<td>21</td>
</tr>
</tbody>
</table>
Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics)

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.

There were enough clinical educators to support staff learning and development. Clinical educator roles had protected time allocated to them within the staffing rotas. Clinical educators supported newly qualified staff and signed off their competencies once they had completed them.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. All nurses employed within the service were registered children’s nurses. Staff rotated between ward 10, the paediatric emergency department, the neonatal unit and paediatric recovery. This allowed staff to develop their skills, experience, complete appropriate training and develop a holistic understanding of the needs of the whole service.

Information provided following our inspection stated that 82% of eligible staff were competent in high dependency (HDU) care across the service. The service did not provide a target for this training.

Staff were trained in life support, 90% of eligible nursing staff were trained in Paediatric Intermediate Life Support (PILS), 92% of eligible nursing staff were trained in European Paediatric Life Support (EPLS) and 91% of medical staff were trained in EPLS. This meant that there was always someone on duty who could provide support in an emergency.

Managers gave all new staff a full induction tailored to their role before they started work. Staff confirmed their attendance at the induction. Newly qualified members of nursing staff completed a preceptorship period. This meant that staff were allocated time to transition from a student to a qualified member of staff.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that their appraisals were useful.

From May 2018 to April 2019, 95.5% of required staff in services for children and young people received an appraisal compared to a trust target of 80%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>29</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>11</td>
</tr>
</tbody>
</table>
The trust’s 80% target was met for all staff groups, with 93.0% of nursing staff receiving an appraisal. The trust did not supply detailed medical staff appraisal data; however, they did provide the trust wide statement below:

For 2018/19 the trust achieved 100% compliance for category one medical appraisals. Over this time period, 12% of the total number of doctors eligible for appraisal were classified as category two which is approved incomplete or missed appraisal due to qualifying criteria e.g. maternity leave. There were no doctors in category three (unapproved incomplete or missed appraisals).

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

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff told us that their development needs were identified in their annual personal development plan meetings. Managers provided ad-hoc supervision and staff told us that managers were approachable and highly supportive.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff worked together across the service to provide support, learning and debriefs to their colleagues. Junior medical staff led weekly teaching sessions and received support and supervision from their senior colleagues.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received specialist training to support staff in their role. Managers arranged staff away days within the service. Speakers from the local adolescent mental health unit attended one of the away days for ward 10 to provide training specific to the needs of some patients who were admitted to the ward. The training included strategies to manage challenging behaviour.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. The ward managers who were responsible for the acute wards and the community service regularly met with the head of neonatal, children and young person’s services, to discuss improvements that could be made within the service to improve the care of children and young people.

A full multidisciplinary team meeting took place on a monthly basis. Daily ward rounds took place, and the paediatric safeguarding lead attended these once per week.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. The trust provided a community paediatric service. The community and acute services worked well together. For example, the joint working between the

<table>
<thead>
<tr>
<th>Estates and ancillary</th>
<th>2</th>
<th>2</th>
<th>100.0%</th>
<th>80%</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery registered</td>
<td>53</td>
<td>57</td>
<td>93.0%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
<td><strong>112</strong></td>
<td><strong>95.5%</strong></td>
<td><strong>80%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>
two teams enabled children to be discharged home with intravenous (IV) cannulas in place, for the community paediatric nurses to administer IV antibiotics, in their home environment.

Staff told us that patients had good access to multidisciplinary team members, including physiotherapy and speech and language therapy. Play therapists supported medical and nursing staff by implementing distraction techniques when children were receiving treatment and helping children to prepare for surgery.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. Staff on ward 10 described positive working relationships with the local child and adolescent mental health service (CAMHS). Staff liaised with CAHMS to arrange mental health act assessments when required. Mental health staff were located within the trust premises which promoted integrated care for children and young people.

**CQC Children and Young People’s Survey 2016 – Q23**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 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)

**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. Children and young people were reviewed by consultants. There was 24 hour/seven days a week consultant cover in place. Consultants operated a ‘hot week’ rota system where they were available out of hours, which ensured cover was available at all times.

Staff could call for support from doctors and other disciplines, including mental health services, pathology and diagnostic tests, 24 hours a day, seven days a week.

Support from the local child and adolescent mental health service (CAMHS) was available seven days per week. Staff could contact CAMHS Monday to Friday between 9am and midnight, and from 9am to 1pm at weekends. Out of hours, staff could contact the local crisis team if appropriate.

**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 area. Varied information was provided to children, young people and their families on a range of topics, for example, healthy eating and lifestyle. Information signposted children and their families to other relevant agencies, where appropriate.

The neonatal unit provided information on a range of topics, such as but not limited to; infant feeding and safer sleeping practices to help support new parents.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle. The trust provided all young people and their families with a copy of the ‘Ready Steady Go’ document when they were planning for transition into adult
services. The main purpose of the document was to empower young people to manage and lead on their own health care.

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 understood Gillick competence and Fraser guidelines and supported children who wished to make decisions about their treatment. Staff could describe the Gillick competence and how this would be used when assessing children’s capacity. Gillick competence is a legal principle for assessing a child’s capacity to consent to medical treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available. All records we reviewed had consent to treatment forms signed. Staff provided a range of information through discussions and leaflets to support children, young people and their families to make informed decisions about their care and treatment.

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. This was supported by the trust consent policy.

Mental Capacity Act and Deprivation of Liberty training completion

All clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.

Trust level

The trust advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust set a target of 90% for completion of MCA/DoLS training.

A breakdown of compliance for adult safeguarding training modules including MCA/DoLS training from May 2018 to April 2019 at trust level for qualified nursing staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In services for children and young people the target was met for both adult safeguarding training modules incorporating MCA/DoLS training for which qualified nursing staff were eligible.

A breakdown of compliance for adult safeguarding training modules including MCA/DoLS training from May 2018 to April 2019 at trust level for medical staff in services for children and
young people is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In services for children and young people the target was met for both adult safeguarding training modules incorporating MCA/DoLS training for which medical staff were eligible. Both modules had completion rates of 100%.

(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 and about the same as other trusts for three questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. Question 54 did not have a score.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</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>8.8</td>
<td>About the same as other trusts</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>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.8</td>
<td>About the same as other trusts</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>9.0</td>
<td>Better than other trusts</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 children</td>
<td>No score</td>
<td>No score</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-11 children = asked of children aged from eight to 11 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Staff understood the relevant consent and decision-making requirements of legislation and guidance which included the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Patient records we reviewed demonstrated that where required, discussions had taken place with both the child and parent.
Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target. This training was incorporated into the trust’s adult safeguarding training modules.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that they were able to access policy documents via the trust intranet if they needed to.

**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 their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. The service utilised ‘clown doctors’. Clown doctors were volunteers dressed as clowns who visited the ward and provided laughter and distractions for unwell children. We saw another volunteer during our inspection who made balloons into different shapes and gave them to children.

Children, young people and their families said staff treated them well and with kindness. All children, young people and families we spoke to told us that staff treated them well and could not do enough for them. We observed positive interactions between staff and children; staff spoke to children in a friendly and open way. They were encouraging towards children by praising them for how well they were doing and offered comfort and reassurance when needed.

We spoke with a play specialist who told us they ensured pictures children had recently created were displayed so that the children felt valued. They also ensured the displays on the walls included a mixture of stylised and unstructured work, to support children to feel encouraged that they would be able to participate.

Staff followed policy to keep care and treatment confidential. Staff were mindful when speaking about children’s care and treatment. Where possible, discussions took place in private areas away from other patients and visitors.

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 expressed they always held a non-judgemental attitude towards children, young people and parents. Discussions with staff about mental health concerns demonstrated staff had understanding and a non-judgemental attitude. We observed that staff were sensitive to all those within their care.

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. Chaplaincy, pastoral and spiritual services were available for children, young people and families to access when required.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for two questions and about the same as other trusts for the remaining eight questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</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>9.0</td>
<td>About the same as other trusts</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.8</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>9.6</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people’s personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. The families of children and young people that we spoke with told us that staff were very helpful, answered any questions they had and took any concerns they raised seriously. Families described that they had felt looked after by staff.

Staff supported children, young people and their families who became distressed in an open environment, and helped them maintain their privacy and dignity. Play specialists were available to help children cope with pain, anxiety or any fear they might experience during their admission or visit to clinic. Various distraction tools and toys were used to engage children and young people of...
various ages and abilities. For example, there was a model MRI scanner which was used to show children what to expect during the procedure to help alleviate any fear and help them to feel calm.

Staff demonstrated empathy when having difficult conversations. Staff informed us that when having difficult conversations, they explained things clearly yet sensitively and gave practical information. We observed that discussions with children, young people and their families were not rushed, and staff asked whether they had any questions or whether there was anything else they needed.

Staff understood the emotional and social impact that a child or young person’s care, treatment or condition had on their, and their families, wellbeing. Staff recognised these factors in their assessments of children and young people, and included that information to ensure all staff involved in their care were aware of it. Staff provided support to children young people and their families by signposting them to external support agencies.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for one question and about the same as other trusts for the remaining four questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</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>9.0</td>
<td>About the same as other trusts</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>8.6</td>
<td>About the same as other trusts</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children</td>
<td>8.9</td>
<td>About the same as other trusts</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 children</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age

(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. Staff provided written information to support discussions about care and treatment. Staff told us they had discussions with families and directly with children and young people, and checked their understanding. We saw this while observing staff interactions with families.
Staff talked with children, young people and their families in a way they could understand, using communication aids, such as pictorial faces and a Makaton book where necessary. People’s individual preferences and needs were reflected in how care was delivered. Families told us that staff provided them with support and information about options for care and treatment for their child.

Children, young people and their families gave feedback on the service and their treatment and staff supported them to do this. The children’s outpatient area had a child friendly method for gaining feedback from children by encouraging them to write on a cardboard fish for positive feedback and a crab for negative feedback. These were displayed in the children’s outpatient area. One feedback card said, “I love the interactive floor games, my favourite is stamping on balloons”.

Staff supported children, young people and their families to make informed decisions about their care. Young people were encouraged to make their own care choices and take a lead on their own health care through the use of the ‘Ready Steady Go’ document when they were planning for transition into adult services.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for one question and about the same as other trusts for 17 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

Questions 66, 69 and 70 had no score.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</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>9.3</td>
<td>About the same as other trusts</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>7.5</td>
<td>About the same as other trusts</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>9.4</td>
<td>About the same as other trusts</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>8.3</td>
<td>About the same as other trusts</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>8.9</td>
<td>About the same as other trusts</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>8.5</td>
<td>About the same as other trusts</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<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>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
0-7 adults = asked of parents and carers of children up to seven years of age
0-15 adults = asked of parents and carers of children up to 15 years of age
8-15 children = asked of children aged from eight to 15 years of age
12-15 children = asked of children aged from 12 to 15 years of age

(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. In the 12 months prior to our inspection, the service had 10 admissions of children to adult areas. Of those 10, eight were to an intensive care unit and one was admitted to a high dependency unit (HDU) under the care of a paediatrician and nursing care was provided by a paediatric registered nurse. This meant that the majority of admissions to the service were into a relevant clinical setting.
Staff maintained effective relationships with other healthcare providers to coordinate patient care, where required. For example, service leads liaised with local hospitals to arrange how they could support each other, such as arranging to take some HDU patients from other trusts in order to make beds available to meet the needs of the local population.

Information provided by the trust following inspection stated that the trust worked with the relevant education agencies to ensure education was maintained for children who had been absent from school for 15 or more continuous days. The play therapy team supported this process by liaising with the parents, carers, children and the tutors assigned to them to ensure that children were offered education that met their individual needs.

Staff coordinated and combined multiple appointments where appropriate. This meant children, young people and their families could attend multiple clinics on the same day if required. For example, a multidisciplinary diabetes clinic was set up in children’s outpatients which meant that a child or young person could see a consultant, a nurse and a dietician in one clinic appointment. There was also an allergy clinic where children and young people could see a consultant, a nurse, have allergy testing and see a diabetic nurse if relevant. Within the same appointment children and young people saw the consultant again where a plan was made, treatment provided and training was arranged.

Facilities and premises were appropriate for the services being delivered. At the time of our previous comprehensive inspection, published November 2015, the children’s outpatients waiting area was shared with women who were attending antenatal clinics which did not meet the needs of either patient group. Since our last inspection, the children’s outpatient clinic was relocated to a designated area for children only.

The operating theatre had a designated recovery area for children that was separate from adult recovery.

The service had a jungle themed treatment room which was located off the ward. Staff carried out some procedures in the treatment room to prevent children from associating their bed space with a negative experience.

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. Support from the local child and adolescent mental health service (CAMHS) was available seven days per week. Staff could contact CAMHS Monday to Friday between 9am and midnight, and from 9am to 1pm at weekends. Staff could contact the local crisis team out of hours if appropriate.

The service had systems in place to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The service utilised the nationally recognised ‘Ready, Steady, Go’ programme for children with long term conditions moving on to adult services. This programme ensured that children’s and adult’s services work together in an integrated way to ensure a thorough and comprehensive transition. Named leads for the young person’s transition were identified from specialties, who liaised with adult services to develop a streamlined transition of care for the young person.

The trust had developed their young person’s transition pathways since our last inspection, for example, service leads told us that diabetes and epilepsy had well established transition pathways, however, not all transition pathways were established. Service leads told us that this was a national issue, in some specialties there was no equivalent adult service for the child or young person. For example, within the learning disability specialty, a child would see a paediatrician only in child services, however, they would be required to see lots of different professionals once they transferred to adult services.
Managers monitored and took action to minimise missed appointments. There were systems and processes in place to identify and respond to patients who did not attend appointments. Managers ensured that children, young people and their families who did not attend appointments were contacted to rearrange a further appointment. Staff recognised the potential need to involve the safeguarding team if they had concerns or if there were repeated missed appointments.

The service relieved pressures on other departments when they could treat children and young people in a day. Ward 10 offered long term open access to children and young people. All children and young people had 24 hours open access to the ward following discharge, however staff assessed whether children and young people required longer open access on a case by case basis depending on complexity.

### CQC Children and Young People’s Survey 2016

The trust performed better than other trusts for one question, about the same as other trusts for 13 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. Questions 55, 2 and 3 had no score.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</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>9.8</td>
<td>About the same as other trusts</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>9.3</td>
<td>About the same as other trusts</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>9.4</td>
<td>About the same as other trusts</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>5.2</td>
<td>About the same as other trusts</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>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.8</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38</td>
<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>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40</td>
<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>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>57</td>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>71</td>
<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>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how</td>
<td>8-15</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question Number</td>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>RAG</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>to look after yourself after you went home?</td>
<td>CYP</td>
<td></td>
<td>as other trusts</td>
</tr>
<tr>
<td>2</td>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>3</td>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>No Score</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 children, young people and their families 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. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. This included children and young people with protected characteristics under the Equality Act, children and young people who may have been approaching the end of their life, and those who were in vulnerable circumstances or who had complex needs.

Play specialists supported the service to meet the needs of children and help them cope with anxiety. For planned surgery, children were introduced to the area, so they could familiarise themselves with the environment. Play specialists used a model MRI scanner to show children what would happen during the procedure. They were able to play the sound of an MRI scanner to children to help prepare them for the procedure.

Community staff provided an example of support they offered to a specific family. The child’s parents were unable to read and write, staff allowed for longer visiting times to enable them to explain things more clearly and check their understanding.

Community staff who provided end of life care to children and young people continued to visit families to offer their support following their death, or at the end of cancer treatment to offer further support if the families wished for them to do so.

One member of staff we spoke to told us that they had come into work on their day off to attend an appointment at a different department with a mother and her baby as the mother felt anxious about it. Staff built trusting and supportive relationships with people who used the service.

The trust had a domestic abuse coordinator and 30 domestic abuse champions within the trust which resulted in raising the profile of domestic abuse throughout the trust. The implementation of domestic abuse champions led to a marked increase in referrals from both patients and staff.

Radiology services prioritised children’s imaging in the morning and allowed parents to stay with children and young people if they wished. In cases where a child or young person had complex needs and required general anaesthetic, the anaesthetist commenced the process with the child or young person in their home. The child or young person was transported via ambulance and recovered at home after the procedure.
Wards were designed to meet the needs of children, young people and their families. Ward 10 had a play area designated for young children which contained toys and books. There was a separate area for adolescents with a television, DVDs and books. A computer gaming system was available, and the ward had free Wi-Fi which patients and their families could access. There was a child friendly x-ray room and play area designed as a seaside theme. There was a quieter room available to use if a child or young person became distressed while awaiting an x-ray.

Staff supported children and young people living with complex health care needs. The trust had a learning disability and autism liaison nurse who was electronically notified of admissions, including any attendance in the emergency department. Staff completed an additional care plan for children and young people with learning disabilities, which clearly set out their specific care needs. Staff could contact the learning disability and autism liaison nurse who was able to provide support with care planning to ensure the complex needs of children and young people were met.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Staff were able to get information in large print and different languages, including Makaton when required. Staff were aware of different cultural and language needs within the local population. Makaton is a language programme that uses speech, signs, and symbols to help people who find communication difficult, especially those with learning disabilities.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff knew how to access telephone and face to face interpreting services.

**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**

From May 2018 to April 2019, the trust’s neonatal bed occupancy was lower than the England average in every month with the exception of August 2018 when it was 100%. From November 2018 to April 2019, the trust’s neonatal bed occupancy was 0%.

![Graph showing neonatal critical care bed occupancy from May 2018 to April 2019.](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The senior sister on ward 10 also supported and had oversight of the paediatric
emergency department. This allowed the emergency department to be reviewed by a paediatric manager and supported a smooth flow throughout the service for children and young people.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. The service provided data that showed from February 2019 to August 2019, the average waiting time for children to receive their elective treatment was 13.1 weeks which was below the national target of 18 weeks. The longest waiting times occurred in August 2019 with an average wait of 16.93 weeks, and the shortest was April 2019 with an average wait of 9.96 weeks. Children and young people have the right to receive treatment, according to the NHS constitution, within a maximum number of 18 weeks.

The service operated a ‘golden ticket’ arrangement with GP surgeries to send children to ward 10 later in the evening after the GP surgery has closed to the public. Rapid access to ward 10 was offered to children who did not require an urgent assessment but were not able to wait for an outpatient appointment.

Managers monitored waiting times and made sure children, young people and their families accessed emergency services when needed and received treatment within agreed timeframes and national targets. Ward 10 included a paediatric assessment unit (PAU) which was available 24 hours a day, seven days a week. Referrals to PAU were accepted via the emergency department, GP’s, health visitors, midwives or other specialist routes.

Managers worked to keep the number of cancelled appointments to a minimum. The trust had a did not attend (DNA) policy that was specific to children and young people. There was a flowchart to guide staff on what action to take if a child or young person had not attended an appointment.

Managers monitored that children and young people’s moves between wards/services were kept to a minimum. There was one paediatric ward within the trust which included PAU, this minimised movement from being assessed to admission.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff told us that discharge planning took place at the beginning of a child or young person’s admission at the hospital. We saw evidence of discharge planning within medical records we reviewed.

Staff planned children and young peoples’ discharges carefully, particularly for those with complex mental health and social care needs. Hospital and community staff within the trust worked closely to help plan children and young peoples’ discharge. Staff told us there was a transition period for discharges home. The community paediatric nursing team met with children, young people and their families on a number of occasions in hospital prior to discharge to ensure everything required was in place at home before discharge.

Staff liaised with the local child and adolescent mental health services (CAMHS) to support children and young people with mental health needs to help plan discharges to appropriate environments, depending on the needs of the child or young person.

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 children, young people and their families in the investigation of their complaint.
Summary of complaints

Children, young people and their families knew how to complain or raise concerns. All family members that we asked told us that they knew how to raise a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Leaflets which included information on how to raise concerns were displayed in ward areas. This included Patient Advice and Liaison Service (PALS) details on how to make a formal complaint.

Staff understood the policy on complaints and knew how to handle them and the importance of supporting people who raised concerns. Staff told us they would try to resolve concerns before they progressed to formal complaints if possible. Staff directed people to the complaints process and provided them with the details needed to make a complaint if needed.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed the last two complaints received by the service. We found information shared with complainants was clear, included investigation findings, identified what action had been taken to address concerns and when learning had been shared with staff.

From June 2018 to May 2019 the trust received 14 complaints in relation to services for children and young people (6.3% of total complaints received by the trust). The main subject of complaints was values and behaviours of staff (6).

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>6</td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>All aspects of clinical treatment</td>
<td>1</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

For the five complaints that had been closed at the time of data submission, the trust took an average of 60.4 working days to investigate and close these. This is similar to their complaints policy, which states complaints should be closed within 60 working days.

The nine complaints that had not yet been closed had been open for an average of 111.1 working days at the time of data submission.

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

Number of compliments made to the trust

From May 2018 to April 2019 there were 28 compliments received for services for children and young people (3.6% of all received trust wide).

Compliments were received in 10 of the 12 months of this period. November 2018 was the month where the most compliments were received (7).

The trust did not provide a breakdown by subject for compliments received.
Staff knew how to acknowledge complaints, and children, young people and their families received feedback from managers after the investigation into their complaint. The trust sent feedback that addressed the entirety of complaints and provided details to children, young people and their families of what to do if they were not satisfied with the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that managers shared feedback from complaints in local meetings. This was reflected in clinical governance meeting minutes. We reviewed minutes from May, June and July 2019 and complaints were discussed as a standing item on the agenda.

**Is the service well-led?**

**Leadership**

Leaders had the skills, knowledge, experience and integrity to run a service providing high-quality sustainable care.

Leaders had the skills, knowledge, experience and integrity that they needed. The trust had an executive lead for services for children and young people. The trust had a head of neonatal, children and young people’s services as well as a clinical lead for the service. Leaders understood issues within the service and wider organisation and were active in their roles.

Leaders understood the challenges to quality and sustainability within the service and identified the actions needed to address them. For example, one of the challenges within the service was the current management structure and some staff members were working above their role to mitigate challenges to the service. This was recognised by the head of neonatal, children and young people’s services who was in the process of proposing a business case for a new service structure.

Staff informed us that management were approachable and supportive and also stated that the senior leadership team were visible. The leadership team provided support to teams following an incident.

Senior leaders told us that sustainable, compassionate, inclusive and effective leadership was a priority within services for children and young people. The service had strong working relationships with the local child and adolescent mental health service (CAMHS) which meant that the service had access to the appropriate mental health expertise.

**Vision and strategy**

There was a clear vision to deliver high quality sustainable care to people who used services, however there was not a service specific strategy at the time of our inspection, although it was in the process of being developed.

Services for children and young people was within the division of surgery and women’s and children’s services.
The trust had a strategy which incorporated services for children and young people. There was no service specific strategy at the time of our inspection, however service leads told us that they were in the process of drafting a neonatal, children and young people strategy. All leads within the service contributed to the new strategy.

At the time of our inspection the head of neonatal, children and young people’s services had recently reviewed the paediatric element of the trust strategy. The strategy was previously reviewed annually, however, due to the changing nature of the service it was being reviewed quarterly.

The majority of staff were aware of the trust vision and values and could tell us what they were. The trust values were putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly.

The strategy was aligned to local plans in the wider health and social care economy. For example, one action included in the trust’s clinical strategy was to achieve the secretary of state’s ambition to reduce by 50% the rate of stillbirth, neonatal death and brain injuries by 2025.

Culture

Staff promoted a positive culture of providing high quality sustainable care which was reflected by leaders in the trust.

The culture of the service centred on the needs and experiences of children young people and families who used the service. Senior staff on the wards we visited throughout our inspection told us that they were proud of the care their staff delivered.

Staff felt supported, respected and valued. Staff spoke positively about their ward and unit managers, they told us managers were always supportive and valued each member of staff. Staff described the service as a positive environment to work within.

Medical and nursing staff we spoke with informed us that they had positive working relationships with one another.

Staff we spoke with told us they felt confident that they could raise any concerns they had to their manager and they felt they would be listened to and concerns would be acted upon.

The trust held an annual award ceremony to celebrate the achievements of staff throughout the year. At the latest awards ceremony, ward 10 achieved the ward of the year award, a community paediatrician won consultant of the year and a nursery nurse won staff member of the year.

Governance

There was a governance structure in place with processes and systems of accountability to support a sustainable service.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and a good quality sustainable service. Children’s specialty meetings took place on a monthly basis across the acute and community services. There was a monthly paediatric clinical governance meeting which incorporated the entire service, both acute and community. This
reported into the divisional clinical governance group where issues were escalated. Minutes from the paediatric clinical governance group from May, June and July 2019 showed that action logs were assigned to staff to complete, service leads told us they used action logs to hold themselves to account for the performance of the service.

All levels of governance and management functioned effectively and interacted with each other appropriately. An agenda item within the paediatric clinical governance group meetings included any issues for escalation or consideration for other committees or groups. Items discussed within the meetings included complaints, reflection of learning, risks and safeguarding issues. We saw evidence that action logs and incident logs were reviewed and updated within the meetings.

The trust safeguarding leads told us that the board received a safeguarding report on an annual basis. The last report was presented by the safeguarding leads in January 2019. We reviewed the most recent safeguarding children and adults report. It included progress made in safeguarding processes, including information systems, training and learning shared throughout the trust.

There was a system in place to ensure that governance arrangements were aligned with national safety standards for invasive procedures. The trust had a children’s surgical working group which was attended by senior nurses and a general surgeon with links to paediatrics.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and demonstrated the ability to cope with both the expected and unexpected.

There were comprehensive assurance systems and processes to manage current and future performance. Staff had access to a comprehensive business continuity strategy dated January 2019 which was due for review in 2022. The strategy clearly outlined action to be taken and who held responsibility to complete the actions in the event of a business continuity incident. For example, it was the role of the executive team or a senior manager to declare a business continuity incident.

There was a systematic programme of internal clinical audits to monitor quality, operational and financial processes, and systems to identify where actions should be taken. Following our inspection, the trust sent details of their audit programme. It included 10 audits that were carried out within the service and stated the priority of the audit, planned audit dates or indicated whether they were ongoing audits. For example, but not limited to; an audit on review of a neonate by a senior clinician within 24 hours, paediatric emergency department referral audit and a re-audit on constipation in children and young people.

Risks were captured on the service’s comprehensive risk register. There were robust arrangements for identifying, recording and managing risks, and mitigating actions. There was alignment between the recorded risks on the register and what staff told us was ‘on their worry list’. The frequency that risks were reviewed depended upon the severity of the risk. The higher risk items on the risk register were reviewed monthly, or more frequently if required. All risks had a review date on the risk register which were all within date.

Performance data was captured manually which enabled service leads to understand how the service was performing. Waiting times were reported to the local clinical commissioning group (CCG). The service planned to utilise a performance dashboard for the entire service. This was due to be used in mid-September 2019.
Information management

Appropriate and accurate information was being effectively processed, challenged and acted upon.

The service collected reliable data and analysed it. Data collected was discussed at specialty meetings. Service leads told us they were assured they had a good understanding of service performance. There were plans in place to further improve the service’s understanding of performance with the development of a service dashboard which was planned to incorporate the acute and community aspects of the service. We saw plans for introduction of a dashboard being discussed in children’s acute speciality group meeting minutes.

Staff had sufficient access to information about the service and challenged it appropriately. We reviewed the minutes of the children’s acute speciality group meeting from May, June and July 2019. There was evidence of scrutiny and challenge. For example, it was documented that sepsis audit results were being reviewed and actions were highlighted to improve outcomes for children and young people.

Information technology systems were used effectively to monitor and improve the quality of care. Staff had access to a national system that identified children who had safeguarding child protection plans in place. This enabled staff to ensure appropriate measures were in place to improve the quality of care for children and young people.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People’s views and experiences were gathered and used to shape and improve the service and culture. The service participated in the friends and family test to gain feedback from children, young people and their families. During our inspection, we saw numerous examples where feedback had been actioned, for example, the service installed a vending machine outside the children’s outpatient area so that children, young people and their families did not have to walk a long way to the restaurant for a drink or snack.

Service leads told us that the service facilitated a ‘takeover day’ where they linked with a local school and invited children to come into the hospital for the day. They engaged in various activities. For example, they were shown around the clinics and had their blood pressure checked. The service also had links with a local sixth form college. Some students attended the same takeover event and video recorded the event as part of a project.

The trust engaged with staff through an annual staff survey. Results from the 2018 staff survey showed that staff felt staffing levels and senior managers acting on feedback were areas of concern throughout the trust as a whole. Positive indicators included staff knowing their responsibilities and the organisation encouraged staff to report errors, near misses or incidents.

There were positive and collaborative relationships with external partners to meet the needs of the population. Service leads engaged with other leads from nearby hospitals, to see what other hospitals were offering and identify any gaps in their own services that they could learn from and use to improve their own service. This was also used as an opportunity to share good practice with
other trusts within the local area. Leads identified they needed to recognise child’s voice throughout the service. This was an area that the service leads planned to address within the service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Leaders and staff strived to achieve continuous learning, improvement and innovation. One member of staff was presented with the Norfolk High Sheriff award in recognition ‘of great and valuable services to the community’. This was following the implementation of domestic abuse champions within the trust which led to a marked increase in referrals as it raised the profile of domestic abuse.

Newberry child development centre developed an innovative way to try to combat local difficulties in medical staffing. The centre was in the process of creating and upskilling a multi-disciplinary staffing model, rather than relying on a medical one. It reflected the trust’s awareness of local difficulties in recruiting and retaining doctors and its commitment to improving services.

The children’s safeguarding lead sought opportunities to participate in local safeguarding children’s boards and steering groups. This enabled the safeguarding team to identify themes within the trust’s local area and drive appropriate action from other agencies. The safeguarding team saw the entire community as their responsibility to safeguard, not only the children, young people and relatives who attended the hospital.

The service conducted some research projects. For example, the service led some research in type one diabetes. It was displayed in the children’s outpatient clinic inviting participants to join. Feedback was displayed from people who had already participated in research, including “I feel really lucky that we’ve been given the chance to help skills and treatments to develop”. Service leads told us that the trust was starting to increase its research portfolio and there were two research nurses within the trust.

End of life care

Facts and data about this service

The service provides end of life care at James Paget Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a service. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The service had 1,165 deaths from March 2018 to February 2019.

(Source: Hospital Episode Statistics)

Please note that the service’s specialist palliative care service was recommissioned in April 2019 and is now provided by a local community interest company.
The service provided the following information regarding their end of life care services:

Since the recommissioning of the specialist palliative care service in April 2019 to a local community interest company, the hospital inpatient palliative care is delivered by a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people, to support them to live as well as possible during their illness, ensuring their comfort and dignity as they come to the end of their lives.

Palliative care services are provided for people, over 18 years of age, with a progressive life-limiting illness, with or without co-morbidities, where the focus of care is on quality of life. These needs may be physical, psychological, social and/or spiritual. Examples include symptom control, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions. Generalist teams benefit from the support the service can offer in these areas. All inpatient wards are able to refer directly into the inpatient palliative care service where referrals will be triaged by the nursing team and turned around within 12/24 hours of receipt of referral. The patients will then be reviewed by either the nurse-led team or by speciality doctors who will refer onto the specialist palliative care service, if this is required.

The service is working towards the delivery of the National Gold Standard Framework programme to deliver training and education to their frontline generalised staff, optimising care for their patients approaching their end of life.

The specialist palliative care service is now provided by another service via a hospice based in Ipswich who provide an in-reach service to the service four mornings per week as well as offering a 24/7 telephone support service. The hospice is also the provider of specialist palliative care to the service’s patients within the community, as well as having access to six specialist palliative care community beds based at a local hospital. Both teams work collaboratively to support patients’ palliative care needs which include weekly MDT meetings and regular interface meetings to ensure a smooth transition to the service’s patients.

All areas within the service are able to sign-post patients, carers and families to the Louise Hamilton Centre (LHC) who offer services for people with life limiting and progressive illnesses. The LHC provides a range of palliative care services delivered in a suitable environment, where not only the physical needs of the patient are assessed and treated, but also the psychological, social and spiritual concerns of patients and their families are explored and supported. The LHC offers both commissioned and charitable funded services and continues to develop their services to support the service’s patient needs.

(Source: Acute Routine Provider Information Request (RPIR) – Context acute tab)

Due to the number of core services inspected, our inspection of James Paget Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the service. The service’s end of life care service was rated overall as requires improvement following its last inspection in July 2018.

During our inspection, we spoke with 31 members of staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We visited seven wards, the bereavement centre, the multi faith room, the Louise Hamilton centre, the emergency department and the mortuary.
Unfortunately, at the time of our inspection patients were too ill to speak with, and no families were available to speak to us. We reviewed three sets of patient records who were end of life and considered other pieces of information and evidence to come to our judgement and ratings. We spoke with members of staff specifically related to end of life care including the director of nursing (DON), end of life care nurses, speciality doctors, specialist palliative care consultant, mortuary anatomical pathology technologist (APT), chaplaincy staff and volunteers.

**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 service set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from May 2018 to April 2019 at service level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>2</td>
<td>6</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>1</td>
<td>6</td>
<td>16.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical gases</td>
<td>1</td>
<td>6</td>
<td>16.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 1)</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 service had an overall mandatory training compliance rate of 58.1% for qualified nursing staff. The 90% target was met for one of the 14 mandatory training modules for which qualified nursing staff were eligible.
It should be noted that, for some modules not meeting the target, this was due to only one or two members of staff not completing the training. Therefore, performance should be considered in this context when dealing with low numbers of eligible staff.

A breakdown of compliance for mandatory training courses from May 2018 to April 2019 at service level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia - 3 year</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In end of life care the service had an overall mandatory training compliance rate of 100% for medical staff. It should be noted that the data only includes three eligible staff. Therefore, performance should be taken in context when dealing with low numbers of eligible staff.

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

During our inspection we asked the service for additional data regarding basic life support training. Data provided showed staff achieved 100% compliance. The service informed us that the end of life care team had been through a significant staff change, which will have affected the training data provided to us prior to inspection.

Nursing and medical staff received and kept up-to-date with their mandatory training. Staff we spoke with said they completed training face-to-face and completed on-line training on the trust’s intranet.

Staff we spoke with told us that managers monitored mandatory training and alerted staff when they needed to update their training. Mortuary staff achieved 100% compliance with mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

The service was six months into delivering the Gold Standard Framework (GSF) in-hospital programme. Data provided by the service following our inspection showed 60% of clinical staff who are included in the GSF training figures (doctors, nurses and allied health professionals) have accessed GSF training and awareness raising.

Following our inspection, the service provided additional data that showed 100% of nursing staff were trained in the use of syringe pumps. The service expected all practitioners to maintain and monitor their own competency and ask for support, as required. The service provided syringe pump training for all new starters as appropriate and offered staff bespoke end of life care training.
All nursing staff who participated in the “IV Programme” received syringe pump training as part of that course and ward managers monitored staff equipment training and competencies as part of their normal staff appraisal and supervision.

**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 service set a target of 90% for completion of safeguarding training.

The tables below include prevent training as a safeguarding course. Prevent works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at service level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – 3 Yearly</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the service had an overall safeguarding training compliance rate of 84.8% for qualified nursing staff. The 90% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

It should be noted that, for the three training modules not meeting the target, this was due to only one to three eligible staff not having completed the training. Therefore, performance should be considered in this context when dealing with low numbers of eligible staff.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Following our inspection, we asked the service for updates in relation to safeguarding which showed all end of life staff were 100% compliant with safeguarding training.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at service level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff</th>
<th>Number of eligible</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) – 3 Yearly</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT (WRAP) – one off</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>trained</td>
<td>staff</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>---------</td>
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<td>-------</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Safeguarding children (Level 2) 2 3 66.7% 90% No
Safeguarding adults (Level 1) 2 3 66.7% 90% No
PREVENT (WRAP) – one off 2 3 66.7% 90% No
Safeguarding children (Level 1) 2 3 66.7% 90% No
Safeguarding adults (Level 2) 2 3 66.7% 90% No
Safeguarding children (Level 3) – annual 1 3 33.3% 90% No

In end of life care the service had an overall safeguarding training compliance rate of 61.1% for medical staff. The 90% target was not met for any of the six safeguarding training modules for which medical staff were eligible.

It should be noted that, for the training modules not meeting the target, this was due to only one or two eligible staff not having completed the training. Therefore, performance should be considered in this context when dealing with low numbers of eligible staff.

(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 said the service had focused on improving safeguarding training rates following our last inspection and data supplied by the service showed improvement from our previous inspection.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them in line with the trust’s safeguarding policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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. We observed the end of life care service-maintained standards of cleanliness, infection control and hygiene through effective systems, policies and procedures and staff disposed of clinical waste safely.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were aware of and practiced infection prevention and control in line with national guidance. Handwashing facilities and hand sanitiser stations were readily available throughout the wards.

We observed staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff following hand hygiene, ‘Bare below the Elbow’ guidance, and wearing personal protective equipment (PPE) such as gloves and aprons whilst delivering care in line with the trust’s policy. The wards had a plentiful supply of PPE and we observed staff restocking as required.

Mortuary staff explained how porters transported known infectious patients to the mortuary in body bags and that these patients underwent post mortem at the end of the day to reduce the risk of cross infection.
Mortuary staff kept mortuary areas visibly clean and tidy and completed records of daily, weekly and monthly cleaning for all areas of the mortuary. We reviewed the cleaning records, which showed staff had signed and dated when they had completed tasks and there were no gaps in the records.

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, maintenance and use of premises and equipment throughout the end of life care service was suitable and kept people safe. Staff cared for patients receiving end of life care on general wards.

On ward 12, the service used a dedicated side room for patients identified as being in their last days of life. The room was decorated with a swan wall mural, and the corridor leading to the room had a nature mural. The service planned to adopt the Swan scheme later in 2019. The Swan scheme is a national scheme implemented in 47 NHS services, within the UK. Swan stands for sign, words, actions and needs, staff who followed the scheme offered dedicated support to patients in their last days of life and to their families into bereavement and beyond.

Ward 17 had single occupancy rooms for all patients. Staff told us that, where possible on other wards, patients had an option to have a side room, where they had private and quiet surroundings if this was what they wanted.

The service had enough suitable equipment to help them to safely care for patients. Staff were able to access syringe pumps which met current national safety standards, to provide medicines to patients approaching the end of their life. The end of life care team stored syringe pumps in individual locked boxes in a filing cabinet. The locked boxes were a tamper free safety mechanism and nursing staff only used syringe pumps within the locked boxes. The ward nurse in charge held the keys to the box with the main drug keys, this prevents patients accessing the pump and accidently overdosing.

Syringe pumps had unique serial numbers and included the equipment service dates. The end of life care team kept records of the location of syringe pumps, and which patient had been discharged with a syringe pump. However, staff told us recently there had been challenges in managing this system and they were in the process of holding an amnesty for returning syringe pumps within the hospital and community to ensure stocks were available.

Access to the mortuary was via swipe card and the entrance was under surveillance by closed circuit television (CCTV). Only staff who worked in the mortuary, bereavement team and portering staff had access to the mortuary.

Mortuary staff carried out waste segregation. All clinical waste bins had the correct coloured bin liners, sharps bins were assembled, and the attached label completed correctly. These containers were within the recommended fill level to minimise the risk of needle stick injuries.

The mortuary was licenced by the ‘Human Tissue Authority’ to allow post mortem examination and storage of the deceased, the service performed two to three post mortems per month. The service wide estates department maintained and held records of mortuary equipment maintenance and service, such as trolleys, hoists and air handling units (a device used to regulate and circulate air). Records showed all equipment was serviced and maintained in line with planned preventative maintenance.
Refrigeration temperatures were consistently monitored. The mortuary had an alarm system which alerted the hospital switchboard and maintenance teams, who were available 24 hours a day to respond to any problems, should the refrigerators fail.

The mortuary had contingency plans in the event of major disaster or air handling unit failure.

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. The service used the national early warning score (NEWS) system in line with national guidance. Nursing staff used NEWS to determine the degree of illness of a patient based on six vital signs, respiratory rate, oxygen levels, temperature, blood pressure, heart rate, and observations. We reviewed the records of three patients at the end of their lives and found staff had recorded NEWS appropriately. In one record staff had clearly documented when a patient no longer required NEWS as this would be intrusive to the patient’s end of life plan and may disturb them unnecessarily.

Medical staff completed clinically agreed plans (CAPs) for all patients receiving end of life care. The CAP was agreed between healthcare teams and the patient or family, so that everyone involved in the care of the patient knew how to proceed if they suddenly deteriorated. A patient’s CAP included not escalating to intensive care or not performing cardiopulmonary resuscitation. Nursing staff increased or decreased patient observations based on the patient’s individual symptoms and condition.

Staff worked together to provide end of life care that respected patient wishes and escalated any concerns to the on-call palliative care consultant at the local hospice. Staff provided additional guidance and support, for example, further symptom management to promote patient comfort and dignity.

Staff completed risk assessments for each patient on admission or arrival and updated them when necessary using recognised tools, for example, universal malnutrition score, pressure score or risks of falls. Nursing staff completed the essential assessment and care booklet which contained assessments of risks including, falls, wound care, pressure area care and personal hygiene. Nursing staff reassessed risks every three days unless a change occurred which indicated an earlier reassessment.

Nursing staff accessed pressure relieving equipment such as air mattresses for those patients who were identified as being at increased risk of pressure sores. We reviewed the records in relation to an end of life patient receiving pressure care due to a care home acquired pressure sore being identified on admission. Staff had a detailed care plan in place, which included support from a tissue viability nurse.

Ward staff used patient referral forms to inform the end of life care team or made a telephone referral when patients required end of life care nursing management. Ward nursing staff confirmed the end of life care team responded very quickly to referrals, usually seeing patients in the same shift and patient nursing records we reviewed confirmed this.
The end of life care team maintained a central list of all patients who were receiving end of life care detailing the ward areas where they were being cared for. This enabled them to identify patients approaching their last days of life and provided them with timely treatment and support daily.

Nursing staff accessed mental health guidance and advice from a speciality doctor who worked for the service two days per week and had a background and special interest in mental health. Alternatively, the end of life care staff could contact the hospitals mental health liaison nurse for advice or call an out of hours community mental health service for telephone advice.

We observed shift changes and handovers included all necessary key information to keep patients safe and staff shared key information to keep patients safe when handing over their care to others.

**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.

Please note that the service’s specialist palliative care service was recommissioned in April 2019 and is now provided by a local community interest company.

**Service level**

The table below shows a summary of the nursing staffing metrics within end of life care at service level compared to the service’s targets, where applicable. Please note the service does not have target vacancy and turnover rates.

<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>35</td>
<td>5%</td>
<td>44%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>11</td>
<td>-4%</td>
<td>79%</td>
<td>1.3%</td>
<td></td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)
Nurse staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover or sickness. There was no bank or agency usage.

Please note that the negative vacancy rate for qualified nurses in the table above indicates that the service was slightly over-established. In addition, the service’s specialist palliative care service was recommissioned in April 2019 and is now provided by a local community interest company. However, the service did not adjust their establishment level for nursing staff in this month, causing a large spike in vacancies. In addition, the high annual turnover rate for nursing staff was due to 9.2 whole time equivalent nursing staff leaving over the 12-month period.

The service had enough nursing staff of relevant grades to keep patients safe. We discussed the changes in staffing with the end of life manager, who explained these had changed due to the specialist palliative care team contract changing to an alternative provider in April 2019.

The hospital core end of life team was now established and the hospital directly employed two full time and one part time registered nurses, with one full time registered nurse vacancy. There were no concerns regarding nursing levels within the end of life team and the service was actively recruiting for this vacancy.

Vacancy rates
Reporting on vacancy rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.

Turnover rates
Reporting on turnover rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.

Sickness rates
Reporting on turnover rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.

Bank and agency staff usage
The service did not use bank or agency staff.

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.

Service level
The table below shows a summary of the medical staffing metrics within end of life care at service level compared to the service’s targets, where applicable. Please note the service does not have
target vacancy and turnover rates.

<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 (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>35</td>
<td>5%</td>
<td>44%</td>
<td>2.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>4</td>
<td>36%</td>
<td>53%</td>
<td>0.1%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within end of life care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover or sickness. There was no bank or locum usage.

Please note that the service’s specialist palliative care service was recommissioned in April 2019 and is now provided by a local community interest company. However, the service did not adjust their establishment level for medical staff in this month. This, in combination with the low medical staff number, contributed to the high vacancy rate shown in the table above.

In addition, the high annual turnover rate for medical staff was due to 1.2 whole time equivalent medical staff leaving over the 12-month period. The low number of substantive staff in this core service impacted on the rate.

Medical staffing met the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care standard (NCPC) which states there should be a minimum of one consultant per 250 beds. The hospital recently employed a full-time speciality doctor to support the end of life care team Monday to Friday. Access to a specialist palliative care consultant was available via a contract with a local hospice and service staff told us they could call the hospice out of hours for any additional medical advice. This was an improvement on our last inspection.

**Vacancy rates**

Reporting on vacancy rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.

**Turnover rates**

Reporting on turnover rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.
Sickness rates

Reporting on turnover rates would not be proportionate given the small size of the team and the change in provision in April 2019, would show disproportionate turnover rates.

Bank and agency staff usage

The service did not use bank or agency staff.

Staffing skill mix

The service always had access to a specialist palliative care consultant on call during evenings and weekends.

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. Nursing and medical staff across the service recorded clinical data and patient care episodes well and the last days of life care plan was comprehensively competed. This was an improvement on our last inspection.

Nursing staff completed an essential assessment and care booklet for all patients, this record contained all risk assessments relating to patient care. Nursing staff also completed a blue multi-disciplinary booklet for all patients. This contained the clinically agreed plan (CAP), completed and signed by a medical professional. The record also included information about the patient, such as, if they had a learning disability or dementia and specific cultural and religious beliefs. In addition, staff completed the plan of care for last days of life for any relevant patients.

Medical staff completed a CAP form for those patients whose last days of life were likely to be in hospital and a separate do not attempt cardiopulmonary resuscitation (DNACPR) form was available for those patients who were likely to die in the community setting. We reviewed three and found these to be comprehensively completed by staff, with family engagement and other relevant professionals. The service carried out its own review of DNACPR forms in June 2019 and found 97% of patient escalation and treatment plans completed, the 3% was due to one patient who was unsure of their treatment plan at the time the audit was taking place.

Medical and nursing staff completed the plan of care for the last days of life booklets for patients who were in their last days of life. The plan of care was holistic and included an initial medical assessment and nursing assessment, along with an assessment of the patient’s mental health cultural and spiritual needs. The care plan was based on the five priorities of care (recognise, communicate, support, plan and do) and the aim was to ensure that dying patients and their families received the best level of care and support during the last days of life.

We reviewed three patient paper medical records and nursing notes. All records showed detailed conversations held between a doctor the patient and their family, which included recognition of dying, symptom control, and assessment of nutrition and hydration needs.

Nursing and medical staff completed patient records to a high standard. Records were detailed, included information shared with relatives, the multidisciplinary team and the patient to ensure their individual needs and choices were met.
The end of life care team nurses used a sticker to identify their entries in the patient care records for ease of recognising any previous reviews.

Records were not always stored securely. On all the wards we visited, staff stored patient medical records in folders in a notes trolley. Staff stored the notes trolley near to the nurse’s station but did not lock it. Nursing staff stored nursing notes in folders at the patient bedside.

Nursing staff completed a rapid discharge checklist at the back page of the plan of care within the last days of life document. This ensured the patient had the correct anticipatory medications, equipment and DNACPR documentation in place. Anticipatory medication is medication prescribed in anticipation of patient symptoms, designed to enable rapid relief at whatever time the patient develops distressing symptoms.

The mortuary had a system for checking deceased patients into and out of the mortuary. We reviewed patient records within the mortuary and found these comprehensive and contemporaneous. Staff explained the process of checking deceased patients into the mortuary and ensuring their personal effects and any family or patients previous wishes were respected at the time of their death and following last offices.

**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. The service used anticipatory prescribing (medications that are prescribed for use on an ‘as required’ basis), to control pain for patients who were in the last hours or days of life. Staff used a triage document which advised on medication doses to control symptoms such as breathlessness, pain and nausea. This was considered good practice by the National Institute for Health and Care Excellence (NICE).

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. We observed an end of life multidisciplinary team meeting where staff openly discussed patients pain relief, changes in medication and suggested pain management that would be suitable for each patient.

The service used one type of syringe pump for continuous pain relief. Nurses told us these were easily accessible, and staff were confident in using them effectively. Registered nurses had received syringe driver training, and the hospital submitted training records to confirm this.

We looked at the syringe pump prescription and administration record. The record had clear guidelines and instructions for drug management for patient symptoms in their last few hours or days of life. The record also contained pain scoring and a triage tool used for different symptoms, for example, oxygen levels and breathing rate.

We looked at the syringe pump prescription and administration record for three patients. Nursing staff had clearly documented the patient’s allergy status, two nursing staff had signed the record to confirm they had set up the syringe pump. Nursing staff had completed, signed, recorded the time, and dated records appropriately at each four-hourly check. This meant that any patient who was end of life received a symptom review as a minimum on a four-hourly basis.
Ward staff documented and reviewed anticipatory medicine. One medical care record we reviewed evidenced medical staff stopped non-palliative medication aimed at prolonging life, when the patient was in their last days and hours of life. This is considered good practice by the National Institute for Health and Care Excellence (NICE).

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.

(Source: Strategic Executive Information System (STEIS))

From May 2018 to April 2019, the service reported no never events for services for end of life care.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with service policy and in accordance with the Serious Incident Framework 2015, the service reported one serious incident (SIs) in end of life care which met the reporting criteria set by NHS England from May 2018 to April 2019. This was the abuse/alleged abuse of an adult patient by a third party which occurred in June 2018.

(Source: Strategic Executive Information System (STEIS))

We spoke with the mortuary staff team in relation to a recent incident in the mortuary. All staff were aware of the incident, the actions being taken by the service and explained that the family had been informed. A full investigation was taking place, and staff explained that any learning from the incident would be shared amongst them and the wider teams who may access the mortuary to reduce any future incidents of that type.

Staff understood the duty of candour and understood the need to ensure patients and families were given a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with explained feedback was shared via email, service news letters or in team meetings with managers.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
During our inspection we observed that 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.

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had an end of life strategy 2017-2019 that referred to various national standards and guidance, for example; the five priorities of care set out in Once Chance To Get it Right (2014), developed by the Leadership Alliance for the Care of Dying People (LACDP), Treatment and Care Towards the End of Life: Good Practice in Decision Making, General Medical Council (July 2010), and National Institute for Health and Care Excellence (NICE) (2017). Quality standard Care of dying adults in the last days of life end of life care for adults (QS144). At the time of our inspection the service was in the process of reviewing this strategy and developing their strategy for 2019-2021.

At our last inspection, the service was working towards independent accreditation in the form of the Gold Standard Framework (GSF). The GSF is a model that enabled good practice to be available to all people nearing the end of their lives, irrespective of their diagnosis. The GSF provided the service with a framework for a planned system of care in consultation with the patient and their family, also promoting better coordination and collaboration between healthcare professionals. There had been improvements made since our last inspection, the service had started to roll out the GSF, provided training for staff and all ward areas had posters and guidance to encourage staff participation in the scheme.

The personalised plan of care for the last days of life recognised the priorities for care according to the Leadership Alliance for the Care of Dying People: A national framework for local action 2015-2020. The Leadership Alliance for the Care of Dying People promoted a consistent approach to end of life care through five key principles.

Staff signposted patients receiving end of life care and those close to them to the Louise Hamilton centre. The Louise Hamilton centre is a charitable centre based on the hospital site where patients and their families accessed information on emotional, psychological and bereavement support as well as other therapies.

Mortuary staff cared for deceased patients in line with guidance from NHS Good Practice Guide for Mortuary Staff.

We observed at handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.
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 adjusted for patients’ religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and we noted in the records we reviewed that staff recorded this within the multidisciplinary care record. Staff encouraged patients to eat and drink, and for as long as they were able to in their last days of life.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Nursing staff completed the Malnutrition Universal Screening Tool (MUST) for all patients to identify patients at risk of malnutrition. This was in line with National Institute for Health and Care Excellence (NICE) QS 15 statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Throughout our inspection, we observed all hospital staff ensured patients had drinks within easy reach and routinely offered them fluids during the day. Staff gave an example of a patient in their last days of life that had requested mushroom soup as their favourite food. This wasn’t on the menu, but the catering team prepared fresh mushroom soup for the patient to enable them to have something to eat.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. Nursing staff had access to a hospital wide team of dieticians based on site. Staff knew how to refer a patient for dietetic support when required. Dieticians provided advice on alternatives for patients, for example, soft foods and high calorie drinks as alternatives to solid foods.

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. We observed during our inspection that patients received pain relief soon after requesting it. Staff also completed intentional rounding, to observe patients frequently and check pain levels. Nursing staff used the Abbey pain score tool for those patients who were nonverbal. This was in line with National Institute for Health and Care Excellence (NICE) QS 15 statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

We reviewed three patient prescription records and found staff prescribed, administered and recorded pain relief accurately. This meant staff met the Core Standard for Pain Management in the UK (Faculty of Pain Medicine, 2015) including, 6.5 (Standard 1) ensuring patients receive a pain assessment. In addition, 6.5 (Standard 2) access to analgesia must be available within 24 hours following a pain assessment and 6.5 (Standard 3) and carers must receive adequate information on the use of analgesics especially strong opioids.

The service had up to date guidelines for the management of pain for patients in the last days of
life. These guidelines were available through the trust’s intranet and within the syringe pump prescription and administration record, which ensured staff had easy access to the information.

Anticipatory prescribing (medications that are prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life) followed the NICE guidelines for symptom control. Where appropriate, staff used a syringe pump, which delivered measured doses of pain relief medication over 24 hours and records we reviewed showed staff managed these in line with the trust’s policy.

Staff on all the wards we inspected told us, the end of life care team provided guidance on the most effective and appropriate treatments and care for patients at the end of life, which included pain relief and management of nausea and vomiting. Out of hours, staff accessed an on-call consultant from the local hospice that could provide additional support and guidance for pain relief and control.

**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 relevant national clinical audits. At the time of our inspection the service was participating in the new National Audit of Care at the End of Life audit, however, it was too early to analyse any data from this process.

Managers used information from the audits to improve care and treatment. For example, the audit in relation to fast track discharges had identified the need for additional staff training to enable staff to complete the discharge paper work and the service provided bespoke training to address this issue.

Managers shared and made sure staff understood information from the audits. Staff received feedback from the end of life operational group which contained data in relation to patient and audit outcomes.

The service planned to adopt the Swan scheme later in 2019. The Swan scheme is a national scheme which is present in 47 NHS services within the UK. It stands for sign, words, actions and needs and staff following the scheme offer dedicated support to patients in the last days of life and to their families into bereavement and beyond.

**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**

Staff we spoke with told us that managers supported staff to develop through yearly, constructive appraisals of their work.

From May 2018 to April 2019, 59.1% of required staff in end of life care received an appraisal compared to a service target of 80%.
The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
<td>Individuals required</td>
</tr>
<tr>
<td>Additional professional scientific and technical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

The appraisal completion rate for nursing staff within end of life care did not meet the service’s 80% target, with 42.9% of staff receiving an appraisal. It should be noted that this reflects four out of seven eligible nursing staff not having received an appraisal, so performance should be taken in context when dealing with low numbers of eligible staff. Data provided by the service following inspection showed 95% of staff in the end of life care service had completed an annual appraisal in the last 12 months.

The service did not supply detailed medical staff appraisal data; however, they did provide the service wide statement below:

For 2018/19 the service achieved 100% compliance for category 1 medical appraisals. Over this time period, 12% of the total number of doctors eligible for appraisal were classified as category 2 which is approved incomplete or missed appraisal due to qualifying criteria e.g. maternity leave. There were no doctors in category 3 (unapproved incomplete or missed appraisals).

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with within the end of life care team were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were experienced nurses, who had worked in the end of life services for many years, with a wealth of knowledge and understanding of supporting patients and their families during end of life.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. End of life care staff we spoke with told us appraisals were important and an opportunity to discuss their personal and professional development.

Managers gave all new staff a full induction tailored to their role before they started work. We noted that new staff were actively encouraged to participate in the trust induction process, which included orientation to the various teams and departments, as well as completing areas of training and competencies appropriate to their respective role.

Managers recruited, trained and supported volunteers to support patients in the service. Part of this process was the development of the services own butterfly scheme where volunteers would be trained to support patients in the last days of life, sitting with them in the absence of family members or providing them additional support during busy periods on the wards.
The service was rolling out training on ‘SAGE & THYME’. ‘SAGE & THYME’ was a mnemonic that acted as an aid memoire for a structured conversation with a person in distress or with concerns. ‘SAGE’ gets the user into the conversation and ‘THYME’ gets them out which staff used when having difficult conversations with patients and families.

**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. During our inspection we attended an MDT meeting, staff respected each other’s professional background and encouraged challenge and discussion to ensure patients and their families were accessing appropriate care and support.

Staff routinely worked across health care disciplines and with other agencies when required to care for patients. For example, social care teams regarding discharge and hospice staff regarding additional care support.

**Seven-day services**

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

The end of life care team was not available as a 24/7 on site service. At least one end of life care nurse and one speciality doctor was available in the hospital Monday to Friday with access to a palliative care consultant on call out of hours and during the weekends from a local hospice.

Staff accessed the mortuary Monday to Thursday 8am to 4.30pm and Friday 8am to 1pm. Mortuary staff provided a 24 hour on call service for the coroner, patients and their relatives. This allowed them to facilitate relatives’ viewing family members and admission of the deceased from the community 24 hours a day. Mortuary staff had good relationships with local funeral directors and provided access to them at appropriate times to release deceased patients ready for funeral preparation.

The multi-faith chapel was open 24 hours a day, seven days a week for staff, patients, and visitors to access. The hospital chaplaincy service had chaplains of various denominations that could be contacted to provide holistic support for staff, patients and families 24-hours a day, seven days a week.

The portering team had access to the mortuary 24 hours a day, seven days a week, which enabled prompt transfers of deceased patients from clinical areas to the mortuary. Staff we spoke with said consultants led daily ward rounds on all wards, including weekends and patients were reviewed by consultants depending on their care pathway.

**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. Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle, for example, offering smoking cessation.

**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.

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

The service advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The service set a target of 90% for completion of MCA/DoLS training.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at service level for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the target was met for one of the two adult safeguarding modules incorporating MCA/DoLS training for which qualified nursing staff were eligible.

It should be noted that the training module not meeting the target was due to only one eligible staff not having completed the training. Performance should be taken in context when dealing with low numbers of eligible staff.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at service level for medical staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Service Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults (Level 1)</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

In end of life care the target was not met for either of the adult safeguarding modules incorporating MCA/DoLS training for which medical staff were eligible.

It should be noted that the training modules not meeting the target was due to only one eligible staff not having completed the training. Performance should be taken in context when dealing with low numbers of eligible staff.
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patent records contained mental capacity assessments, and staff used a green form to record the mental capacity assessments. This meant medical staff assessed mental capacity consistently across the service and the green form was easily visible in patient care records.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff we spoke with showed good understanding of mental capacity and best interest decisions, they worked closely with the trust’s safeguarding team on any complex cases, advanced decisions or power or attorney processes.

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

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke described and knew how to access policy and get accurate advice on 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.

The service did not provide any data for medical staff completion rates of mental health law training.

**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.*

Feedback from people who use the service, those close to them and stakeholders was continually positive about the way staff treated people. Throughout our inspection we found staff recognised and respected the totality of people’s needs. Staff spoke with respect about individuals choices and worked with them to achieve these. Staff considered patients and their families cultural, personal, social and religious needs whilst care planning or discussing individual choices with patients and their families. Staff empowered people and their families, practically and emotionally, to achieve their wishes in the last days of their life and at the end of their lives. We saw examples of this as outlined below.

Feedback from people who use the service, those close to them and stakeholders was continually positive about the way staff treated people. Throughout our inspection we found staff recognised and respected the totality of people’s needs. Staff considered patients and their families cultural, personal, social and religious needs whilst care planning or discussing individual choices with patients and their families.
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. On all the wards we visited staff displayed a culture of compassion and positivity and had a genuine desire to want to provide the best possible care to patients at the end of life.

The service had a commitment to implementing the swan scheme later in 2019. However, many of the staff activities already mirrored the swan scheme commitments in day-to-day patient care and activities.

Staff recently supported a deceased patient’s family to hold a family birthday party, following a patient's death. Staff in the mortuary helped the family to decorate the mortuary viewing room, with balloons and banners and a small family party was arranged with the deceased present.

One patient who was dying asked the service if they could support a last-minute marriage proposal and wedding. Staff from across the service came together and prepared the wedding, arranged the ceremony and supported the wedding event. The patient died shortly after the ceremony, having had the opportunity to have been married with his wife by his bed side.

Staff in the mortuary offered a wide range of personal services, for example, washing patients clothing to be returned to the family, to prevent further distress and reuniting family with treasured personal items. We noted that one deceased patient had requested that a teddy bear was kept with them after their death and this was stored sensitively with the patient in the mortuary area.

Families accessed a range of bereavement services, the dedicated bereavement team showed utmost respect and compassion for family members and the deceased.

Portering staff respected the dignity of deceased patients. Portering staff collected deceased patients from the ward only when nursing staff had closed the curtains around all other patients.

**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. The bereavement team provided families of the deceased with detailed information offering practical help and support following the death of a loved one. Guidance included dealing with the immediate practicalities, such as; how to register a death, arranging a funeral and tissue donation where appropriate.

Staff provided emotional support to patients, families and carers to minimise their distress. Peoples emotional and social needs were highly valued by staff and embedded in their care and treatment. We noted during the multidisciplinary team meeting that staff comprehensively explored options for additional emotional and psychological support. One patient was using positive thinking techniques and prayer to assist their healing. Staff were balancing the patient’s beliefs and choices alongside their daily monitoring and offered additional guidance via counselling services and changes in medication.

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 routinely discussed the social needs of patients to ensure their holistic care needs were met. For example, one patient needed additional support with their mobility to enable them to return home, staff were working closely with the occupational therapy and social worker team to assist in this process.
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. Patients and family were involved in care planning and offered opportunities to discuss their treatment plans and make decisions about their care. For example, we noted in the multidisciplinary staff meeting records demonstrating where staff had engaged actively with patients and families to achieve their preferred place of death.

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. In the records we reviewed we noted medical staff had recorded individual patient and family wishes and been clear in recording any additional support or requests the patients had discussed.

During the multidisciplinary team meetings, staff discussed the needs of patients who had made advanced decisions about their care and what process would need to be in place, specifically when patients were considering their preferred place of death.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to pictorial symbols to aid communication with patients who lacked speech or who needed additional support to express their needs.

The Louise Hamilton centre had access to additional counselling, support and advice for patients. For example, volunteers and staff offered free financial advice, wellbeing promotion and psychological support.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

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. The service was working with the local sustainability and transformation partnerships (STP) to respond to the needs of local people and promote joined up services for end of life care.

Facilities and premises were appropriate for the services being delivered. The service provided open visiting, concessionary parking and tea or coffee with cake for families supporting a patient in the last days of life to try and improved their access to the ward and comfort. Staff told us they offered relatives to stay over if they wished to do so and organised foldaway beds if the patient was in a side room.

On ward 12, the service used a dedicated side room for patients identified as being in their last days of life. The service planned to adopt the Swan scheme later in 2019. The Swan scheme is a national scheme which is present in 47 NHS services within the UK. It stands for sign, words, actions and needs and staff following the scheme offer dedicated support to patients in the last days of life and to their families into bereavement and beyond.
Ward 17 had single occupancy rooms for all patients. Staff told us that, where possible on other wards, patients would have an option to have a side room, where they had private and quiet surroundings if this was what they wanted.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had staff members in place to aid the delivery of care to patients in need of additional support. For example, dementia champions and learning disability link nurses. Nursing staff used dementia symbols (a blue flower) above patient beds to easily identify patients who needed more support.

The Louise Hamilton centre opened in 2013 and provided services such as drop in support sessions, support groups and relaxation activities for people with cancer and other palliative illness. These services were designed to support patient’s psychological and social needs as well as their physical health. There were facilities available for relatives of hospital patients, for example, they were welcomed to go in and use showers, the kitchen, lounge area and the garden.

**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.

The service provided holistic care and met the spiritual, religious, psychological and social needs of patients who received palliative care or who were at the end of their life and their families.

The end of life care resource folder, which was available on all wards, had information for staff on caring for patients living with dementia, those patients who were lesbian, gay, bisexual, transgender or queer (LGBTQ) as well as describing end of life beliefs for all different faiths and cultures.

The chaplaincy gave examples of when naming ceremonies, baptisms and special services had been organised for end of life patients and staff within the hospital.

The chapel was a multi-faith space and was open 24 hours a day, seven days a week for people of any faith or no faith. Prayer mats for people with a Muslim faith, copies of the Holy Bible and Koran and multi-faith books were available. The chaplaincy team also provided coffee and cake mornings and encouraged staff to drop in and take time out to focus on their wellbeing.

Chaplaincy staff and volunteers were visible within the service and accessed religious representatives from all denominations as required and supported people who preferred not to follow a faith or belief. The service was implementing the butterfly scheme, where volunteers are provided additional support and training to spend time sitting with patients and offering them comfort at the end of life, if they have no relatives or if family are unable to be there.

A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following a bereavement.

Nursing and mortuary staff were able to access language line translation services, or face to face interpreters for those patients who did not speak English as a first language. Staff also encouraged the use of on-line translation apps, to assist in translation.

A viewing room in the mortuary provided families or friends a private quiet space should they wish to spend time with the deceased. The waiting room where families sat prior to viewing their loved ones was decorated and furnished with comfortable furniture, helping the families feel at ease. Mortuary staff explained how they could play music if requested and relatives were able to
access the quiet garden outside the mortuary, which was a private space.

The mortuary team explained that they always ensured that people from different faiths and cultures had their needs met. For example, mortuary staff described how a Muslim faith family had come to the mortuary to wash and dress their relative.

At the time of our inspection the mortuary and bereavement team explained there had been a change in practice regarding local death registrars sharing space in offices within the mortuary, and the registrars were no longer on site. The team told us that for some families this had increased travelling and made registering a death more difficult.

Senior staff were considering an alternative venue on site, as this would enable family to use the mortuary and bereavement teams as a “One stop shop” and complete all the necessary registration details on site, while collecting deceased belongings or having meetings with the mortuary and bereavement teams.

The service employed a medical examiner whose office was within the mortuary. Staff explained that this was an improvement and that the medical examiner could now speak with families and provide information to help them understand the death of a loved one.

The mortuary had fridges which were suitable to store the bodies of deceased bariatric patients. We observed that patients were given a choice of food and drink to meet their cultural and religious preferences. Menus for end of life patients were catered for based on their individual needs. Staff went the extra mile to ensure patients had a wide range of choices to meet their cultural and personal preferences. Catering staff prepared individual menu choices, for example a patient’s favourite food, or drink as and when requested.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers and staff worked to make sure that they started discharge planning as early as possible. We observed during multidisciplinary team meetings and ward rounds that staff considered the need for fast tracking patients for discharge. Ward staff we spoke with told us the end of life care team responded quickly to referrals, usually within the same day. Staff understood the importance of timely referrals to reduce any pain or discomfort for patients and ensure they respected any advanced decisions. The trust monitored referral times to ensure patients were seen in a timely manner, aiming to see patients within 24 hours of referral.

The service offered a fast track discharge for those patients who were in the last weeks of life and a rapid discharge and access to funding for those patients identified to be in the last days or hours of life. Fast track funding ensured individuals with a rapidly deteriorating condition, who entered a terminal phase, were supported in their preferred place of care as quickly as possible. It meant that a Clinical Commissioning Group (CCG) takes responsibility for commissioning and funding appropriate care. The service aimed to fast track patients within 48hrs of referral, from April 2019
to September 2019 the service achieved 78% compliance with this target. Delays in achieving the
target were often due to waiting for a choice of nursing home or a delay in the availability of a
package of care if the patient’s normal place of residence was chosen.

The end of life care team carried out an audit of patient preferred place of care at the end of life.
Data provided by the service following our inspection showed that 83% of patients reached their
preferred place of care. The service aimed for all patients to reach their preferred place of death
but recognised this was not always achievable. Seventeen percent of patients did not achieve their
preferred place of care because the patients deteriorated rapidly, became too unwell and died in
hospital

The mortuary had 183 spaces, including spaces for deceased bariatric patients. An additional 20
mortuary spaces were also available in event of an emergency, for example increased capacity
required, in a separate location on the hospital site.

Portering staff received specific training on how to transport deceased patients and had access 24
hours a day seven days a week to the mortuary to maintain patient flow through the mortuary.

Porters made patient transfers to the mortuary a priority. Wards were flexible on these times if the
families wished to remain and spend time with the deceased relative.

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

From June 2018 to May 2019 the service received four complaints in relation to end of life care
(1.8% of total complaints received by the service). The subject of three complaints was all
aspects of clinical treatment and the remaining complaint subject was staff values and
behaviours.

For the two complaints that had been closed at the time of data submission, the service took an
average of 96.0 working days to investigate and close these. This is not in line with their
complaints policy, which states complaints should be closed within 60 working days.

The two complaints that had not yet been closed had been open for an average of 150.5 working
days at the time of data submission.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after
the investigation into their complaint. Staff we spoke with knew how to use the services complaints
process. Complaints leaflets and posters were on display in various part of the hospital.

Managers shared feedback from complaints with staff and learning was used to improve the
service. Staff we spoke with explained that if a complaint was received the managers would
discuss this with them, either on a one-one basis or in a team meeting. Staff said that complaints
regarding the service were unusual and had no specific examples they could share of
improvements being made following a complaint.
We asked the service about the length of time complaints were open. Staff explained that complaints were often complex and needed support from various teams across the service. Complaints were left open until all the details and a formal response had been made. The service felt it better to wait until a complaint was fully resolved rather than reopening the complaint should further information come to light. All complainants were kept informed on the progress of their complaint, and where extensions were required additional time scales were agreed to enable the service time to complete the complaints process.

Number of compliments made to the service

From May 2018 to April 2019 there were three compliments received for end of life care (0.4% of all received service wide).

All three compliments were received in July 2018.

The service did not provide a breakdown by subject for compliments received.

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

Is the service well-led?

Leadership

The service had compassionate, inclusive, and effective leadership within end of life care. Leaders demonstrated high levels of experience, capacity, and capability needed to deliver high quality and sustainable care.

There was strong collaboration, team working, and support within the end of life care team. All staff we spoke with knew who their immediate managers were and understood the roles of senior management in delivering end of life care.

The director of nursing (DON) was the executive lead for end of life care and led the end of life care team alongside a non-executive director for mortality and palliative care. The DON reported back to the board and was responsible for oversight of the end of life care strategy. The DON had significant nursing experience in end of life care, understood the end of life care issues within the organisation and was engaged with improvements being made in the service. Ward staff could name who the executive lead was for end of life care and told us that the DON was visible on the wards and approachable.

Despite a recent change in the way end of life services was delivered across the service, staff felt the changes had been positively led and that managers had been approachable and understanding during the changes. Relationships with a local hospice were highly valued and the service leadership team aimed to strengthen this by having regular staff meetings and planned staff events with the hospice team.

The mortuary had a clear leadership structure. Mortuary staff reported to the mortuary and bereavement manager, who reported to the respective service manager.

Throughout our inspection, hospital staff of all grades and roles regarded the chaplaincy team and its services highly, especially the leadership within the chaplaincy team.
**Vision and strategy**

The service had a clear vision and had an end of life care strategy 2017 to 2019 and staff understood the service plans.

The strategy was distinct from the overall trust organisational strategy and vision and reflected the priorities within end of life care, for example, the strategy included patients and their families living with life limiting conditions other than cancer. At the time of our inspection the existing service strategy was under review and the focus was on developing a strategy that encompassed the wider NHS and end of life care agendas to meet the needs of the local population.

Staff we spoke to were aware of the services end of life care strategy and had active engagement in developing the service going forward by attending meetings and providing feedback to managers on where the series could be improved.

The service implemented and monitored an action plan to monitor the end of life care strategy. The action plan set aims, timescales and success measures and assigned actions to leads within the service and rated compliance with actions.

**Culture**

The service promoted an inclusive culture, that enabled patients to benefit from trained, competent staff who were passionate about their roles in end of life care.

All staff we spoke with throughout the service were passionate about delivering end of life care and ensuring that patients in the last days of life and their families experienced safe, well managed care and support.

The end of life care team felt valued by the leadership team and other staff across the hospital. Despite the recent changes in the service, the end of life care team was positive about the future of the services and looking forward to working alongside the hospice staff to improve end of life care for the patients and family members.

All staff we spoke with told us they felt the end of life care team was a supportive team. Staff interacted in a supportive way within the team to ensure safety and efficiency for patient care.

All staff were proud of the organisation as a place to work and spoke highly of the culture. Ward staff were openly engaged with the service plans regarding the gold standard framework and actively seeking ways to use this new process to quickly identify patients who may be in their last days of life. Ward staff supported a culture of early intervention, seeking to provide comfort and pain relief and engaged families and professionals in the care planning process.

The chaplaincy service was highly respected and valued by staff, who saw this as an extension of promoting staff wellbeing and support for all staff. Staff gave examples of coffee and cake mornings where staff could just drop into the chaplaincy service for a free coffee and cake, to share their thoughts or discuss their wellbeing without fear of reprisals or worries over confidentiality.

**Governance**

The service had clear responsibilities, roles and systems of accountability to support good governance and management within the end of life care services.
We found that all levels of governance and management functioned effectively and interacted with each other appropriately. The service held care at the end of life strategic group (CELSG) meetings quarterly and the care at the end of life operational group (ELOG) met monthly. These groups had representation from multidisciplinary staff across the hospital including allied health professionals, the end of life care team, the clinical leads, junior doctors, learning disability liaison nurse, the chaplaincy team, bereavement leads and the mortuary lead. The focus of the operational group was to improve the care the trust gave to end of life care patients by implementing systems to enhance and support the service’s strategy.

We reviewed the CELSG meeting minutes from July 2019 and ELOG from August 2019. Minutes demonstrated the groups functioned effectively and assigned actions and monitored key performance indicators, for example, patient’s preferred place of care and fast track discharge in order to improve performance and measure quality.

The trust had employed a full-time speciality doctor within the end of life care service on site five days per week, who offered oversight of the clinical quality and day-to-day service delivery of end of life care.

Management of risk, issues and performance

Leaders were aware of the risks, issues and challenges faced by the service and managers we spoke with knew the risks associated with end of life care. This was an improvement on our last inspection.

During our inspection we reviewed the services risk register which was updated by the service at the end of life care strategic group meeting. Each risk was assigned to an executive lead for oversight, assigned a review date and the risk level was rated. Risks were given key controls to mitigate the risk, actions were set and regularly updated. The executive lead for the end of life care service told us that risks were raised through the operational or strategic group and from the patient safety and experience committee.

Following our last inspection in July 2018 the service had made improvements in the way it collated and used performance data to improve performance. Staff routinely collated data on fast track discharges, preferred place of care, and the time taken to patient referral to the end of life care service. This was an improvement from our last inspection.

The end of life care team had a dedicated work programme to provide a structured approach to the essential improvement actions for the end of life care group (ELOG) 2018/19. Key elements in the work programme included providing staff training to recognise patients in the last days of life, improved utilisation of the plan of care in last days of life, enabling preferred place of death and monitoring the implementation of the Gold Standard Framework.

Internal audit processes across the service were becoming increasingly imbedded and audit outcomes were used to improve quality and performance of the service. The service was developing a dashboard to draw together all the quality audits into one place, so they could quickly identity any areas that needed improvement or celebrate success when hitting performance targets.

Information management

The service had a good understanding of performance which integrated people’s views with information on quality, operations and finances.
Service performance and audit data was discussed in operational and strategic meetings within the service and minutes from meetings demonstrated the service challenged its own performance.

Information on end of life services was captured in spread sheet format and at the time of our inspection the service was working to incorporate information within the service’s overall performance dashboard.

Information used to measure quality and performance included a comprehensive audit programme and bereavement surveys. Financial and operational performance was assessed and monitored in line with the services end of life care strategy.

The end of life care team actively participated in national and local audits as part of clear and robust service performance measures reported to the trust board. Local audits included, but were not limited to, preferred place of care, discharge summary audits and regular mortuary audits.

**Engagement**

The service gathered patient, relative and staff views and experiences and acted upon these to develop and improve the end of life services.

The service carried out bereavement surveys sent to a patient’s next of kin following a death to collect feedback on the patient and relative experience. The results of the surveys were discussed at the end of life strategic and operational meetings to identify any areas for improvement or to celebrate success.

The director of nursing participated in the local strategic transformation programme (STP) and attended the end of life and palliative care collaborative group. This was to increase the services presence locally amongst other providers, to respond to service demand and shape services for the future.

All wards that we visited had end of life care champions who supported staff and provided additional information on end of life care. Wards staff we spoke with highly valued this role, as it enabled them to share up to date practise and improve end of life care for patients and their families.

The mortuary team invited staff for tours of the mortuary to give staff an understanding of work within this area and what patients and families experience.

The service used the service’s newsletter which was published quarterly to inform staff of developments and initiatives relating to end of life care.

**Learning, continuous improvement and innovation**

The service used information and performance data to improve its services, this was an improvement from our last inspection.

Staff routinely collated data on fast track discharges, preferred place of care, and the time taken to patient referral to the end of life care service. This was an improvement from our last inspection.

Leaders were aware of the risks, issues and challenges faced by the service and managers we spoke with knew the risks associated with end of life care. This was an improvement from our last inspection.
Access to a specialist palliative care consultant was available via a contract with a local hospice and service staff told us they could call the hospice out of hours for any additional medical advice. This was an improvement from our last inspection.

Staff said the service had focused on improving safeguarding training rates following our last inspection and data supplied by the service showed improvement from our previous inspection.

Outpatients

Facts and data about this service

James Paget University Hospitals NHS Foundation Trust provides outpatient services at James Paget University Hospital, the Newberry Clinic and other satellite premises. The outpatient department covered a wide range of specialities, including trauma and orthopaedics, urology, ophthalmology and general medicine. Between February 2018 and January 2019, there were 350,302 outpatient appointments, of which 269,553 were first or follow-up appointments.

We undertook a short notice announced inspection of this service from 3-4 September 2019, and a follow-up unannounced inspection on 12 September 2019. As part of our inspection, we visited 11 outpatient services and departments, including the Broadland Suite, including the breast unit and oncology; the department of medicine, including diabetic and endocrine services; dermatology, ear, nose and throat (ENT); ophthalmology; pathology; phlebotomy; respiratory and chest; rheumatology; trauma and orthopaedics; and urology.

We spoke with 30 members of staff, including directors, managers, consultants, doctors, matrons, sisters, nurses, healthcare assistants and reception staff. We spoke with four patients, three relatives and reviewed nine sets of patient records.

(Source: Acute Routine Provider Information Request – Context acute tab)

Total number of first and follow up appointments compared to England

The trust had 269,553 first and follow up outpatient appointments from February 2018 to January 2019. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the total number of outpatient appointments 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>This Trust</td>
<td>350,302</td>
</tr>
<tr>
<td>England</td>
<td>108,831,860</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 is in the chart below:

Number of appointments at James Paget University Hospitals NHS Foundation Trust from February 2018 to January 2019 by site and type of appointment
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.

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

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and safety for managers</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities and autism</td>
<td>43</td>
<td>45</td>
<td>95.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia - 3 year</td>
<td>43</td>
<td>45</td>
<td>95.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>39</td>
<td>41</td>
<td>95.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Falls</td>
<td>36</td>
<td>38</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>42</td>
<td>45</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>42</td>
<td>45</td>
<td>93.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical gases</td>
<td>37</td>
<td>42</td>
<td>88.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic life support</td>
<td>35</td>
<td>40</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>39</td>
<td>45</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>39</td>
<td>45</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff received and kept up to date with their mandatory training. In outpatients, the trust had an overall mandatory training compliance rate of 93.1% for qualified nursing staff, which
exceeded the trust’s target of 90%. Overall, the trust met its target for 10 of the 14 mandatory training modules for which qualified nursing staff were eligible.

Of the four modules which were below the trust’s target, the lowest compliant module was fire safety – 1 year, which 39 out of 45 eligible staff (86.7%) completed. Another of the four modules below target was basic life support, which 87.5% of staff completed. We raised this with managers who told us this was due to some staff undertaking a higher-level course, such as intermediate life support or advanced life support. Managers told us these staff did not need to attend the basic life support course, as the higher-level courses also covered this; however, this data still included these staff members.

The trust did not report any medical staff working in outpatients, as other specialities within the trust managed these staff.

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

The mandatory training was comprehensive and met the needs of patients and staff. All staff received training, which was inclusive and relevant to their role and experience. The service delivered training across several formats, including via face-to-face sessions and e-learning modules. Training topics covered a range of topics, including basic life support, health and safety, information governance and infection prevention.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff completed dedicated mandatory training on mental health, which gave them skills for caring for patients who attended clinics with more complex needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received email alerts when mandatory training was due to expire. Managers across outpatient services monitored their team’s compliance and supported staff to complete their training. For example, managers in the trauma and orthopaedic clinic displayed a list when each staff member’s training was due to expire.

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 table below includes PREVENT training as a safeguarding course. PREVENT works to stop individuals from getting involved in or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training modules from May 2018 to April 2019 at trust level for qualified nursing staff in outpatients is below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>37</td>
<td>38</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 2)</td>
<td>36</td>
<td>38</td>
<td>94.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 3) - 3 Yearly</td>
<td>35</td>
<td>38</td>
<td>92.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT (WRAP) – One off</td>
<td>36</td>
<td>40</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (Level 1)</td>
<td>38</td>
<td>45</td>
<td>84.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff received training specific for their role on how to recognise and report abuse. Staff completed safeguarding training as part of their annual mandatory training. Staff explained how they completed safeguarding referrals for patients who attended clinics where staff had concerns. Staff sought specialist advice and guidance from the trust’s safeguarding leads when needed.

In outpatients, the trust had an overall safeguarding training compliance rate of 92.6% for qualified nursing staff, which exceeded the trust’s target. Overall, the trust met its 90% target for five of the six safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children (level 1) was the only module that did not meet the trust’s target, at 84.4% compliance. We requested further data from the trust after our inspection, which showed that 100% of nursing staff within the medical division had completed this training. However, we did not receive updated figures regarding nursing staff within the surgical division.

The trust did not report any medical staff working in outpatients, as other specialities within the trust managed these staff.

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

Staff knew how protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The trust required all staff to follow a dedicated equality and diversity policy. We reviewed the latest version of this policy and saw the trust had reviewed it regularly, within specified timeframes. The policy explained how the trust supported and promoted equality and diversity within the workplace, and how they pledged to ensure no discrimination of staff, visitors or service users occurred, particularly against on any of the protected characteristics under the Equality Act.

Outpatients staff received mandatory training, which covered equality and diversity. Data provided by the trust showed between May 2018 to April 2019, 97.8% of staff had completed this training, which exceeded the trust’s target of 90%.

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 understood their responsibilities under safeguarding and knew how to protect patients from risks of abuse. Staff described several categories of abuse, including domestic violence and neglect. Staff completed regular safeguarding training, which gave them the skills to identify and protect patients who were at risk of potential harm.

Nursing staff we spoke with from outpatient services were aware of how to complete safeguarding referrals and knew when a referral needed completing. If staff needed support or advice, they told us how they could obtain support from the trust’s safeguarding leads.

Staff followed safe procedures for children visiting the service/department. Most paediatric outpatient clinics operated from ‘The Cove’ – a dedicated children’s clinic within the hospital. Although some outpatient clinics still saw children, staff told us this was usually during dedicated paediatric clinic sessions. Staff told us of one specialist dermatology clinic that treated both adults and children together, however plans were in place to move this to The Cove.

Managers told us all outpatients nursing staff received safeguarding children level 3 training, as children often attended the department with their siblings or parents. Data supplied by the trust
prior to our inspection showed that 92.1% eligible nursing staff had undertaken this training, which exceeded the trust’s target of 90%.

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.

The service kept clinical areas clean and ensured all furnishings were suitable, clean and well-maintained. Staff understood and controlled infection risk well. Staff kept outpatient treatment rooms, assessment areas and waiting rooms visibly clean. Seating areas throughout the trust’s outpatient services had wipe-clean coverings, which allowed effective cleaning.

Staff kept cleaning records up-to-date and cleaned all areas regularly. Staff completed daily cleaning checklists in all outpatient areas. These checklists detailed the areas which needed daily checking and cleaning, such as clinic rooms, treatment rooms and waiting rooms. We reviewed checklists from across outpatients services and saw these were all completed and signed appropriately.

Staff followed infection control principles, which included the use of personal protective equipment (PPE). Staff had access to PPE and infection control equipment in all outpatient services we inspected. This included access to aprons, gloves, handwashing stations and alcohol gels. The service placed handwashing charts, which detailed a comprehensive eight-point handwashing process, throughout the hospital to remind staff of correct processes. Managers audited handwashing compliance on a three-monthly process. We reviewed the most recent two audits undertaken in June 2019 and saw all areas had scored 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when staff had last cleaned it. Across the outpatient services we inspected, staff labelled equipment and devices with ‘clean and ready for use’ stickers to show when they had last cleaned each item. On certain equipment, staff undertook daily cleans and applied new stickers, even if the item had not been in use.

For equipment used by multiple patients, such as scopes, staff followed procedures to effectively decontaminate each item of equipment after each episode of patient care. Managers in the ear, nose and throat (ENT) department told us how they aimed for a ‘gold standard’ in equipment decontamination and explained how they sent equipment to a specialist department for an extensive decontamination. However, if staff needed equipment urgently, they explained how they had trained all staff to decontaminate equipment using a ‘three-wipe’ system. This was a specialist external cleaning protocol whereby staff first cleaned equipment using a ‘pre-clean’ wipe, before then applying a second disinfectant wipe followed by a third rinsing wipe. This allowed staff to ensure all equipment remained clean and infection-free.

Environment and equipment

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

The design of the environment followed national guidance. Outpatient services and clinics were clearly signposted throughout the hospital. Maps of the hospital were available for patients to use to find the correct outpatient service. The trust listed the location of each department and
outpatient service clearly on its website, which allowed patients to easily find the desired service. This followed national guidance in the Department of Health’s Health Building Note (HBN) 12: Outpatients Department, which says in section 3.5 that ‘access and circulation routes to and within the [outpatients department] should be sufficiently direct and clearly signposted to prevent patients losing their way within the hospital’.

The trust had decorated outpatient clinics and waiting areas with calming and reassuring colours. This was in line with section 2.2 of HBN 12, which says the ‘layout of the department and the interior design should create a friendly and reassuring environment for patients, escorts and staff’.

Section 3.7 of the HBN states patients should have ‘easy access to treatment facilities and WCs’, and staff should have ‘good visual contact with waiting patients’. We reviewed several outpatient waiting rooms and found they were appropriately sized, and staff had good visual oversight of all patients waiting. Patients could access toilets and cleaning facilities from waiting areas, which met the national guidance requirements.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was available to staff in all outpatient services we inspected. Staff checked equipment daily and utilised tamperproof seals to secure the contents of each emergency resuscitation trolley. Staff had access to defibrillators (a medical device that helps to restart a patient’s heart in case of a cardiac arrest) and checked these regularly.

The service had suitable facilities to meet the needs of patients’ families. The service had appropriately sized outpatient waiting rooms to allow patients to sit with their family, friends or carers. Cold water was available in watercoolers throughout outpatient services. All waiting areas had access to adjoining or nearby toilet facilities.

The service had enough suitable equipment to help them to safely care for patients, however staff did not always monitor manufacturer use-by dates regularly. Each outpatient area had enough equipment to appropriately care for and treat all patients. For example, in the trauma and orthopaedics department, we saw how staff had access to specialist equipment, including several types of walking and mobility aids to aid a patient’s recovery.

We reviewed several items of equipment, including medical devices, consumables and medications, from across outpatient services. However, we found several consumable items stored in trauma and orthopaedics that exceeded manufacturers’ suggested use-by dates. This included a spare resuscitation bag that had expired in October 2018, an adult oxygen mask that had expired in January 2019, a pair of forceps that had expired in April 2019, and two boxes of tubular bandages that had expired in June and November 2018. We raised this concern with the clinic sister at the time of our inspection and saw the service took immediate action to remove the outdated items from circulation.

Staff disposed of clinical waste safely. The service had clinical waste bins, which staff could access easily to dispose of needles and other sharps items. Staff signed and labelled bins clearly and emptied them regularly to ensure they did not exceed recommended fill levels.

Assessing and responding to patient risk

Staff identified, minimised or removed potential risks for each patient. They identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient’s health. If a patient deteriorated whilst they attended an outpatient clinic, staff told us they would undertake an initial assessment
within the clinic. If needed, staff told us they could access resuscitation equipment from trolleys located across the hospital. Staff we spoke with knew where their nearest resuscitation equipment was and how to request urgent medical support.

Staff knew about and dealt with any specific risk issues. We spoke with staff in the ear, nose and throat (ENT) department, who told us how they reviewed each day’s clinic list the day before. They showed us how they checked each patient on the hospital’s electronic record system, which displayed an alert to staff if any patient due to attend may need additional support. Staff told us of a recent situation whereby a patient with known violent tendencies was due to attend the department, however because of the alert, staff had pre-arranged for the hospital’s security team to be present during the clinic.

Staff had access to specialist mental health support services if they were concerned about a patient’s mental health Staff explained how electronic alerts informed them of patients due to attend the department with known specialist needs. Staff told us how they could request support from trust leads for mental health, dementia and learning disabilities when needed. They explained how these teams often visited the department when a patient who was known to need specialist support was due to attend the department.

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. We spoke with staff in the trauma and orthopaedics who explained how they completed an outpatient-to-ward telephone handover, followed by a paper proforma, when they admitted patients to a ward. We reviewed a completed proforma which covered several topics, for example patient allergies, treatment plans, diagnoses, previous medical history, mental health history, nutrition and hydration, mobility and skin integrity assessments.

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.

The service had enough nursing staff of relevant grades to keep patients safe. 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 planned clinic staffing four to six weeks ahead of each clinic. They explained how they received each doctor’s clinic list at least six weeks in advance and used this to calculate the estimated number of patients due to attend each session. Managers then distributed nursing staff so to fulfil each clinic’s demand. In case of insufficient staff being available, for example during periods of sickness or high patient activity, managers utilised bank staff to fulfil any staffing shortfalls.

Managers told us they ensured they did not cancel clinics because of nurse staffing. They explained they flexibly moved staff around the outpatient services to ensure all clinics ran with safe levels of nursing staff. For example, we saw how managers had relocated a neurological nurse to support the dermatology department during a forthcoming weekend clinic session.

The table below shows a summary of the nursing staffing metrics within outpatients at trust level compared to the trust’s targets, where applicable. Please note the trust does not have target vacancy and turnover rates.

| Outpatients annual staffing metrics |
May 2018 – April 2019

<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 (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>100</td>
<td>6%</td>
<td>4%</td>
<td>5.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>38</td>
<td>6%</td>
<td>5%</td>
<td>2.7%</td>
<td>1,143 (2%)</td>
<td>n/a</td>
<td>853 (1%)</td>
</tr>
</tbody>
</table>

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

Analysis of nurse staffing rates within outpatients for the past 12 months showed no indications of improvement, deterioration or change in monthly rates for vacancy, turnover or agency use. The trust did not report any agency usage for nursing staff in outpatients.

Vacancy rates

From May 2018 to April 2019, the trust reported a vacancy rate of 6% for all staff in outpatients. The trust did not have a target for its vacancy rates.

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

Turnover rates

From May 2018 to April 2019, the trust reported a turnover rate of 4% for all staff in outpatients, and a turnover rate of 5% for qualified nursing staff in outpatients. The trust did not have a target for its turnover rates.

Sickness rates

Sickness rate - qualified nurses and midwives

- Data
- Median
- Trend
- Shift

Data Median Trend Shift
The service had variable sickness rates for outpatients staff. Monthly sickness rates from May 2018 to April 2019 for qualified nurses and midwives showed a shift from November 2018 to April 2019. From May 2018 to April 2019, the trust reported a sickness rate for all staff of 5.3%, which was above the trust's target of 4.0%. However, for the same period, the trust reported a sickness rate for qualified nursing staff of 2.7%, which was below the trust's target of 4%.

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

Bank staff usage

The service had a reducing rate of bank staff across outpatient services. Monthly bank hours from May 2018 to April 2019 for qualified nurses and midwives showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank staff. They requested staff who were familiar with and understood the service and made sure all staff had a full induction. Managers explained how most bank staff were staff with prior experience of working within the department, such as staff who had taken up a new role within the trust or previous members of staff who had left a permanent post. The service gave all new bank staff with no prior experience of the department several supernumerary introduction shifts, which allowed them to understand the service.

Managers used bank staff to fill short notice vacancies, such as short notice sickness and unexpected absences. The outpatient service did not use any agency staff.

Medical staffing

The trust did not report any medical staff working in outpatients, as other specialities within the trust managed these staff.

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 nine sets of patient records from across outpatient services and saw staff completed these fully. Clinicians signed, dated and recorded their designation clearly on each record. Each record provided a clear and detailed diagnosis or plan of patient care.

Staff stored records securely. When patients transferred to a new team, there were no delays in staff accessing their records. Most services across the trust used electronic patient records systems, which only authorised staff could access. This allowed staff to access a patient’s current and past medical record, which included records created from other hospital departments, such as the emergency department. For the remaining clinics using paper records, staff stored these securely and kept records out of public view. At the end of each clinic, staff scanned these records onto the electronic system for future access. The service had plans in place to enable all clinics to utilise paperless systems.

Medicines

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

Staff followed systems and processes when safely prescribing, recording and storing medicines. Staff stored medicines across outpatient services in locked medication cupboards and fridges, which only authorised staff could access. The service had fitted medication cupboards and fridges with temperature alarms, which alerted staff if temperatures were out of range. Staff checked these temperatures daily and recorded this on a daily check sheet. If staff recorded a temperature which was out of line, staff told us they escalated this to the pharmacy team, who investigated the issue.

We spoke with staff in the ear, nose and throat (ENT) department, who told us staff complete monthly checks of all stored medications to ensure they were within expiry date. Staff told us they escalated any expired medications to the hospital’s pharmacy teams for disposal.

Clinicians prescribed medications to patients using green NHS ‘FP10’ prescription requests, which local pharmacies dispensed; internal hospital prescription requests, which only the hospital’s pharmacy can dispense; and via GP prescription requests.

The service did not use controlled drugs.

Staff stored prescribing documents in line with the trust policy. All FP10 prescription requests had unique numbers and staff stored these in locked cabinets. When a prescription was issued, staff recorded this in a log, which included the prescriber’s name, prescription request number, patient’s details and medication(s) issued. The trust’s pharmacy team audited these checklists regularly.

In some clinics, such as the ear, nose and throat (ENT) and urology departments, staff followed the same process for issuing internal hospital prescription requests. However, not all clinics followed this process. For example, in dermatology and ophthalmology, there was no log in place to record when each prescription was issued.

We raised this concern with the trust, however they explained how the pharmacy team had controls in place to mitigate this. They explained how only the hospital pharmacy could dispense these prescriptions, and how the trust held specimen signatures of all prescribers, which pharmacists checked prescriptions against. The trust explained how as part of the dispensing process, pharmacists checked to confirm the patient on the prescription was a patient of the trust,
and the medications prescribed were consistent and appropriate for the clinic the patient attended and the prescriber listed. They explained how all internal prescriptions were uniquely identifiable, which allowed for a checking process in case of loss or theft.

Staff followed current national practice to check patients had the correct medicines. The service used electronic systems to access and update patient medical records. When staff accessed a patient’s record, the system displayed key patient alerts to staff, which staff had to acknowledge the alert before they could view the record. These alerts included essential information, such as patient allergies, which reduced the risk of patients receiving incorrect or inappropriate medications.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We spoke with staff in the dermatology clinic, who told us how they received key information alerts and recalls, including drug and equipment recalls. Managers shared this information directly with staff, as well as via staff noticeboards.

**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.

Staff knew what incidents to report, how to report them, and reported all incidents that they should report. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers supported staff after any serious incident. Staff and managers across outpatient services were aware of which incidents they needed to report, including patient safety incidents, near misses and serious incidents (SIs). Staff explained how they reported all incidents using the trust’s electronic incident system and felt comfortable to seek support from colleagues and managers if needed. Managers explained how they reviewed all incidents reported and investigated them where necessary, sharing any learnings with teams.

We reviewed the three most recent incident reports for incidents that had occurred within outpatient services. Each report contained details and experience of the investigation team, along with the scope and level of investigation undertaken, including any root cause analysis. It provided an overview of the incident, including a timeline of events and actions. We saw the report had dedicated sections that detailed the involvement of any patients, relatives and staff affected, including any application of duty of candour, as well as support for the staff involved. We saw how the service asked five questions as part of the investigation, which were: ‘what should happen now?’; ‘what did happen?’; ‘why did it happen?’; ‘what was done about it?’; and ‘what needs to be done now?’. Each report contained a section to detail any lessons learnt and recommendations, including the arrangements for sharing any learnings.

We reviewed the accompanying action plans for these incidents and saw the service had rated each action according to its importance. Managers had assigned each action to a specific individual, or group of individuals. Each action had a due date specified and contained a comments box, which managers updated regularly as each action progressed.

**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 May 2018 to April 2019, the trust reported no never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning with their staff about never events that happened elsewhere. We spoke with staff who told us how managers shared learnings from serious incidents and never events from across the trust with the department, usually in a ‘team brief’ meeting, which took place monthly. We reviewed three incident reports and accompanying action plans and saw how the service had detailed how they planned to share any learnings with staff. For example, one report stated how the service planned to share the incident and analysis at clinical governance meetings, cross-divisional learning meetings and directly with outpatient staff.

Breakdown of serious incidents reported to STEIS

We were unable to assess whether the trust reported serious incidents (SIs) clearly and in line with trust policy, as in accordance with the Serious Incident Framework 2015, the trust reported no SIs in outpatients that met the reporting criteria set by NHS England from May 2018 to April 2019. However, staff we spoke with were aware they should report all potential serious incidents and knew how to do this.

(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. We spoke with managers who had a good knowledge and understanding of duty of candour. They told us this was part of their mandatory training and formed part of their process when investigating incidents and complaints. We reviewed three completed incident reports and saw dedicated sections on the involvement of patients, relatives and any application of duty of candour.

Staff met to discuss the feedback and look at improvements to patient care. The service held several meetings across outpatient services to discuss patient care. For example, managers attended monthly cross-divisional meetings and clinical leadership meetings, during which they discussed incidents and shared any learnings.

There was evidence that the service had made changes because of feedback. We spoke with managers from the ear, nose and throat (ENT) department who told us of how the service had made improvements following patient feedback. For example, they explained how they had improved wheelchair access in the department and how they had obtained higher waiting room chairs because of patient feedback to the service.

Safety thermometer

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

The service continually monitored safety performance. Managers collected safety information and data from several sources, including internal audits, quality reviews, appointment attendance
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 accessed policies and procedures on the trust’s internal intranet system, which were based on national guidelines. Managers undertook audits which referenced external national guidelines. For example, we reviewed the hospital’s ‘making a difference’ audit, which checked staff knowledge and understanding of several areas, including knowledge of the falls risk factors as specified by the National Institute for Health and Care Excellence (NICE).

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The code of practice states how patients should receive treatment in places that are safe, that people should be in hospital for the shortest period time possible, and how providers should plan services, so patients can access them in the most appropriate manner. During our inspection, we reviewed several outpatient clinics and saw these provided patients with a safe environment to receive care and treatment. We saw how staff secured all medications, equipment and storerooms. In addition, staff explained how they locked rooms at the end of each clinic to prevent unauthorised or unaccompanied access.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We spoke to staff and managers in the trauma and orthopaedic clinic who explained how the department had introduced a paper handover proforma for when the service transferred patients to a ward. They explained how this proforma helped to ensure all key information about a patient was handed over, including a patient’s mental health and previous medical history.

Nutrition and hydration

Staff made sure patients had enough food and drink during all clinics.

Staff made sure patients had enough to eat and drink. Water was easily accessible from watercoolers located across the outpatient clinics we visited. Staff explained if clinics ran late by 30 minutes or more, they usually offered patients offered complementary drinks and refreshments.

Although food was not available within the department, patients and relatives could purchase food from several cafés and retail outlets located close by within the hospital. However, staff told us they could obtain food for patients when required. For example, staff in the diabetic clinic told us they had quick access to biscuits and other foods in the event of a patient suffering from low blood sugars. Another nurse told us of a recent situation where they had obtained a sandwich for a patient whose return transport was two hours’ late.

Pain relief
Staff assessed patients to see if they were in pain and gave pain relief as required. They supported those unable to communicate using suitable assessment tools.

Staff gave pain relief in line with individual needs and best practice. In clinics where minor procedures took place, such as the trauma and orthopaedic clinic, staff had access to both oral and local analgesia if patients needed this. For most other outpatient clinics, staff prescribed patients pain relief when needed, which the hospital’s on-site pharmacy service dispensed.

During our inspection, we spoke with four patients and three relatives who raised no concerns about the management of any pain during their clinic appointments.

**Patient outcomes**

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

There were no specific national clinic audits for outpatient services, however several clinics participated in local audits and national research programmes aimed at improving patient services. For example, we spoke with staff in the ophthalmology service who told us how the department took part in several research trials. This included participation in a project aimed at treating dry age-related macular degeneration, which is a common cause of blindness in people aged over 60. They also told us of a second project called the ‘MONARCH’ study, which aims at monitoring for neovascular age-related macular degeneration within a patient’s home.

Several outpatient services also took part in cross-divisional studies and national audits. This included participation in the National Hip Fracture Database by the trauma and orthopaedics department; participation in the National Ophthalmology Audit (Adult Cataract Surgery) by the ophthalmology department; and the National Diabetes Audit by the endocrinology and diabetic clinics.

Managers carried out a local audit programme and used information from audits to improve care and treatment. Managers held engagement meetings to discuss and share audit results with staff, and to monitor and check for service improvement. Managers undertook several local audits across outpatient services. They explained how they completed three regular audits each quarter, which rotated each month. This included a hospital-wide ‘making a difference’ audit, during which managers assessed documentation, management of patient falls, staff and patient communication and mental capacity. A second ‘internal review’ audit assessed the department’s environment and equipment, the patient experience, staff behaviours and patient complaints. The third was the ‘hand hygiene’ audit which assessed staff compliance to the trust’s infection prevention and control procedures, for example, by checking staff wore correct personal protective equipment and washed hands before and after each patient contact.

Managers shared and discussed the results of each audit at team meetings and during monthly managers’ meetings.

**Follow-up to new rate**

From February 2018 to January 2019, the follow-up to new rate for James Paget University Hospitals NHS Foundation Trust was higher than the England average, however this was reducing from a peak in March 2018.
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 had the experience, qualifications, right skills and knowledge to meet the needs of patients. Managers assessed staff competencies before they operated certain equipment or performed certain procedures. Managers made sure staff received appropriate specialist training for their role. We spoke to managers in the trauma and orthopaedic clinic who explained each member of staff had a competency checklist, which managers signed when staff completed a specific procedure, such as taking and recording a patient’s blood pressure.

Managers gave all new staff an induction before they started work. All staff received a hospital induction as part of their initial training. Although not all areas had formal induction programmes, managers told us all new staff received five supernumerary shifts in each outpatient service, which allowed them to become familiar with the service. However, managers in the department of medicine told us they were in the process of developing formal induction programmes to improve support for inexperienced staff.

Appraisal rates

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. From May 2018 to April 2019, 93.3% of required staff in outpatients received an appraisal compared to a trust target of 80%.

The breakdown by staff group is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff who received an appraisal</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>3</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>17</td>
</tr>
</tbody>
</table>
The trust met its target of 80% for all staff groups, except for additional professional, scientific and technical staff. There was a completion rate of 92.9% for nursing staff. The trust did not report any medical staff working in outpatients.

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

Staff had the opportunity to discuss training needs with their line manager and managers supported staff to develop their skills and knowledge. Nursing staff from the department of medicine told us they valued their appraisals and performance meetings. For example, one member of staff explained in their most recent appraisal, managers encouraged them to attend meetings for their own development, and that they found this beneficial.

Department managers explained they were working with a neighbouring NHS trust to facilitate staff development, with the aim of staff working there on away days to gain new/different ideas, knowledge and additional experience.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers held regular team meetings across outpatient services. This included cross-divisional meetings, clinical governance and leadership meetings, and complex drug meetings. Prior to all meetings, the service circulated agendas among staff, with suggested topics of discussion. The service distributed meeting minutes via email after each meeting for staff who were unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers proactively reallocated staff around outpatient clinics as required, which provided opportunities for staff to undertake additional training. For example, staff could learn additional procedures to allow them to work in dermatology clinics.

Managers identified poor staff performance promptly and supported staff to improve. Managers explained they met with their staff to discuss any performance issues or training requirements. In the event of a staff member underperforming, managers would support staff to improve via one-to-one support meetings and additional training. If this was unsuccessful, managers explained how they escalated this to senior management for review.

Managers recruited, trained and supported volunteers to support patients in the service. At the main hospital reception, the trust had set up a dedicated volunteers’ desk, which aimed to help and support patients during their visit to the hospital.

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. Managers held regular meetings across divisions and outpatient services to discuss patient
care. These included monthly governance meetings, clinical leadership meetings and cross-
divisional meetings.

Patients could see all the health professionals involved in their care at one-stop clinics. We spoke
with departmental managers who explained how they were trialling ‘one-stop’ clinics and virtual
clinics to enhance patients’ experience. These helped to minimise the number of times a patient
needed to attend the hospital for treatment, particularly for patients who needed to attend multiple
specialities. The service utilised specialist nurses and clinicians to support clinics. For example,
the service employed specialist breast care nurses in the breast and oncology unit.

Staff worked across health care disciplines and with other agencies, when needed, to care for
patients. The service operated each outpatient clinic with staff from several roles, who worked
collaboratively together to support patient care. This included collaboration between medical staff,
nursing staff, specialist staff and healthcare support staff. Staff worked in partnership with other
hospital departments, such as the emergency department and inpatient wards. Managers worked
with other healthcare providers, including neighbouring NHS acute hospital trusts, to enhance
patient care.

Staff referred patients for mental health assessments when they showed signs of mental ill health
or depression. Staff we spoke with told us how they could seek support from the trust’s mental
health leads if they had any concerns regarding a patient with mental health needs.

Seven-day services

Certain clinics were available at evenings and weekends. Staff could obtain support from
other disciplines when required to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and
diagnostic tests. Most outpatient clinics operated during a variety of hours from Monday to Friday
each week. However, certain clinics operated during evenings and weekends to support patient
demand. For example, during our inspection we saw the service planned to run certain
dermatology and neurology clinics over the forthcoming weekend. Staff from across the hospital
could access support from other disciplines and services, such as phlebotomy, radiology and
mental health services when needed.

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.
Leaflets were available across the patient waiting rooms, which provided patients and relatives
with advice on how to live healthier lives. We saw information leaflets on smoking cessation, skin
care and management of sunburn.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They
knew how to support patients who lacked capacity to make their own decisions or were
experiencing mental ill health.

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. All staff we spoke with during our inspection were aware of the Mental Health Act and the Mental Capacity Act (2005) and told us they received regular mandatory training in these areas.

Staff gained appropriate consent from patients for their care and treatment. 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 made decisions in their best interest, considering patients’ wishes, culture and traditions. Staff recorded capacity and consent in the patients’ records. Staff told us if they had any concerns a patient may not have the capacity to make their own decisions about their care, they would complete a green ‘mental capacity assessment record’ sticker. Staff completed and signed this checklist, which detailed whether the patient had any permanent or temporary impairment or disturbance in the functioning of the brain. Staff then affixed this to the patient’s clinic notes.

If a patient needing medical treatment did not have mental capacity for their own decisions, staff completed a separate consent form. The consent form detailed the proposed course of treatment, an assessment of the patient’s mental capacity, an assessment of the patient’s best interests and involvement of the patient’s family and relatives. If necessary, this would also involve an independent mental capacity advocate (IMCA), a second medical opinion and the patient’s attorney or deputy before staff gave any treatment.

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

The trust advised that all adult safeguarding modules include Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust set a target of 90% for completion of MCA/DoLS training.

A breakdown of compliance for adult safeguarding modules including MCA/DoLS training from May 2018 to April 2019 at trust level for qualified nursing staff in outpatients is below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of 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)</td>
<td>44</td>
<td>45</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (Level 2)</td>
<td>37</td>
<td>38</td>
<td>97.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. In outpatients, the trust met its target for both adult safeguarding training modules incorporating MCA/DoLS training for which qualified nursing staff were eligible.

The trust did not report any medical staff working in outpatients.

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

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could access mental health and mental capacity trust policies on the hospital’s internal intranet system. Staff could seek support from the trust’s mental health leads if necessary.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Data supplied by the trust prior to our inspection showed that there were no Deprivation of Liberty Safeguards applications submitted by outpatient services from May 2018 to April 2019. Managers we spoke with were aware of Deprivation of Liberty Safeguards. Staff received DoLS training as part of the mandatory training programme.
Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Managers assessed the department’s compliance to the Mental Capacity Act as part of the hospital’s ‘Making a Difference’ audit. We reviewed this audit and saw it checked staff knowledge and awareness of Mental Capacity Act and DoLs processes and included a review to audit if staff completed patient records.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update. Most departments within the hospital utilised an electronic patient records system, which authorised staff accessed. For clinics using a paper-based system, staff scanned clinic notes onto the system after each visit. Staff showed us how they viewed both current and historic patient records generated in any area of the hospital, such as the emergency department. This allowed medical staff to obtain a thorough history on a patient’s condition.

**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 were kind, courteous and friendly, and offered help and support to patients during each clinic. For example, we saw staff assist one patient who was unsure where their clinic was, and saw staff accompany the patient to the appropriate reception desk. In the breast unit, we saw a member of nursing staff greet all patients and asked how they were, even though the nurse was not due to see them personally.

The service supported patient chaperones, which allowed for relatives, carers or staff members to accompany patients during examinations.

Patients said staff treated them well and with kindness. During our inspection, we spoke with four patients and three relatives. One patient we spoke with told us how they ‘could not speak highly enough’ of the hospital. They explained how they had attended the hospital several times for treatment and had received ‘tremendous support throughout the pathway’. They told us it felt like ‘staff really care’ and said that staff ‘always remember them and address them by name’.

Staff followed policy to keep patient care and treatment confidential. Staff protected patients’ privacy and dignity wherever possible. Staff knocked on clinic room and treatment room doors before they entered and closed curtains when they gave direct patient care. Staff held discussions on patient care away from public waiting areas to preserve 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. We spoke with staff from the pathology and phlebotomy service who explained they worked with the trust’s mental health leads to support patients attending the department. Staff explained how they had developed a yellow card system, whereby staff gave appropriate patients a yellow card to present in clinic. This card indicated to the receptionist the patient required extra support, without the patient having to repeat or divulge this information in the waiting room. Staff told us how they aimed to prioritise or minimise any delay for the patient, by seeing the patient as soon as possible.
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 from across outpatient services and saw staff were caring and professional. They communicated to all patients in a considerate and respectful manner and used appropriate language and communication techniques for the patient’s age and needs.

We spoke with one relative in the breast unit, who told us how they ‘felt overwhelmed’ that the nurse had ‘clapped their hands and had a really big smile’ when they found out their partner’s scans were cancer free.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they had access to two dedicated quiet rooms in the Broadland Suite, where they could discuss sensitive issues with patients or break any bad news in private.

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. Although not all nursing staff had undertaken specialist training on breaking bad news, staff demonstrated empathy when having difficult conversations. We spoke with staff from the breast unit who told us whilst not all staff had received specialist training for handling difficult situations or when breaking bad news, they felt well supported by the department.

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. They supported patients to make advanced and informed decisions about their care. We spoke with one patient who regularly attended a rheumatology clinic with their relative. They explained how they always saw the same doctor and were ‘happy with how they were treated’. They told us there were ‘lots of opportunities to ask questions’ and ‘things were always explained clearly’.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff told us how they had access to several communication aids to support patients attending clinics. This included visual communication cards, large print and easy access versions of patient leaflets, interpreters and language signers.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff actively sought patient feedback on the care they had received and encouraged patients to provide feedback. Feedback and suggestion boxes were on display throughout the outpatient clinics we visited. Managers analysed the results from these feedback cards and made improvements as a result. For example, in the ear, nose and throat (ENT) department, we saw a dedicated ‘we’re listening to your feedback’ noticeboard, which listed previous patient suggestions that managers had acted upon. This included the installation of higher waiting room chairs, after patient feedback that previous chairs were too low.

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 outpatient clinics. The department utilised the NHS Friends and Family Test (FFT) survey, which detailed how likely
a patient was to recommend the service to their friends and family because of their experiences. We spoke with staff in the trauma and orthopaedic clinic who told us they gave a survey card to every patient each time they attended a clinic.

We reviewed the results of the FFT survey from 1 to 31 July 2019 for all patients who attended outpatient services. For this period, there were 3,364 completed surveys returned, which equated to a response rate of 18.43% of all patients who attended a clinic. Of all returned surveys, 3,238 patients (96.25%) stated they were ‘likely’ or ‘extremely likely’ to recommend the service. Forty-four patients (1.31%) stated they were ‘neither likely to unlikely’ to recommend and 40 patients (1.19%) stated they were ‘unlikely’ or ‘extremely unlikely’ to recommend. Forty-two patients (1.25%) did not know whether they would recommend the service.

We reviewed some of the patient comments written on the survey cards. One patient explained they were ‘frequent attendees and have nothing but praise for the department’. Another patient wrote, their doctor ‘explained everything very carefully’ and how they ‘listened to their questions and asked if they understood everything’. A third patient wrote, from start to finish, their care had been very good. However, we did see a comment one patient had written that stated how they had spent ‘too long waiting’.

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 was involved with local commissioning groups and other healthcare providers, including other local NHS trusts, to provide a comprehensive outpatients service that met the needs of their patients.

Managers met regularly to discuss improvements to the service to meet patient demands, such as the offering of evening and weekend outpatient clinics for certain specialities with high patient demands. Managers told us they continually looked at new ways of organising services to support patients, such as exploring the possibility of new group consultations for certain clinics. This was still in planning stage at the time of our inspection, however managers hoped for the service to support several patients at the same clinic, such as during appropriate follow-up sessions.

The service has systems to help care for patients in need of additional support or specialist intervention. Staff explained how they endeavoured to support all patient needs for patients attending clinics. For example, staff told us how they started some clinics early so doctors could see patients whilst the department was quiet. They also explained how they facilitated for patients to wait in quieter areas of the hospital rather than in waiting rooms during busier clinics.

The service offered several specialist clinics for the assessment and treatment of certain conditions or for patients on certain courses of medications. For example, we saw the dermatology service provided a specialist isotretinoin clinic specifically for the assessment and treatment of patients with severe acne.

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. Managers we spoke with told...
us the department was trialling ‘one stop clinics’, whereby patients could be seen by a number of specialities which related to their condition during one appointment. This aimed at reducing the number of times a patient would need to attend the hospital.

Certain outpatient services, such as the trauma and orthopaedic and ophthalmology clinics, had begun trialling new virtual and telephone clinics. This allowed doctors to review patient scans without the need for the patient to physically attend hospital.

Facilities and premises were appropriate for the services delivered. Most outpatient clinics were on the ground floor of the hospital and were clearly signposted throughout the hospital.

All the outpatient clinic waiting rooms we inspected were fully wheelchair accessible and had accessible toilets available. Water coolers, magazines and other patient literature was available in all waiting rooms. Most clinics had enough seating for all patients and relatives to sit together. However, we observed at peak times, seating was not always available for all patients and relatives in the trauma and orthopaedic clinics.

Staff could access emergency mental health support during clinic hours for patients with mental health problems, learning disabilities and dementia. Staff told us they could seek support and guidance from the trust’s leads for mental health, learning disabilities and autism. They explained how the leads usually visited the clinic to support patients requiring additional support.

**Did not attend rate**

Managers monitored and acted to minimise missed appointments. Patients received reminders when they had an upcoming outpatients’ appointment, including through a telephone reminder seven days before their appointment. We spoke patients in the breast unit who told us the service provided a ‘good reminder service’.

The service contacted patients who did not attend their appointments. We spoke with staff from the trauma and orthopaedic clinic who explained the process they followed for any patient who did not attend their scheduled appointment. Staff told us they stamped the patient’s clinic notes to indicate a non-attendance and attempted to contact the patient directly. Staff then checked hospital systems to confirm if the patient was under any protection list. If they were under any protection order, or if staff had any concerns, they told us they would escalate this to the hospital’s safeguarding team.

From February to December 2018, the did not attend rate for James Paget University Hospitals NHS Foundation Trust was lower than the England average. However, in January 2019, the rate rose to just above the England average.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, James Paget University Hospitals NHS Foundation Trust.**
The service relieved pressure on other departments when they could treat patients in a day. We spoke with staff in the ear, nose and throat (ENT) department, who told us how the emergency department (ED) could refer appropriate patients directly to the clinic for review. Although this usually only occurred during peak periods of demand, staff told us this helped the ED as the clinic could triage, assess and potentially treat the patient in a day. This benefited patients, as they received quick and more specialist care within a dedicated ENT department.

**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. Staff told us how they reviewed all patients due to attend a clinic the day before the appointment on the hospital’s electronic record system. They explained the system displayed several alerts for patients potentially requiring further care or support. This included alerts for patients known to be living with dementia, mental health needs, learning disabilities or autism. Staff told us they would inform the trust’s liaison nurses for any patient due to attend an appointment with an existing alert, so the team could plan to attend and support the patient during the clinic.

If a patient was not known to the hospital and did not have an alert, however required further support, staff explained they would ensure the patient received appropriate care.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff explained how they had access to specialist patient literature that met the needs of patients with a disability or sensory loss. This included large print versions and ‘easy read’ versions, as well as dedicated high contrast versions with black text on yellow backgrounds for patients with visual impairments.

The service had information leaflets available in languages spoken by the patients and local community. Although patient leaflets in English were on display, staff told us they could print off leaflets in other languages when required.
Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service kept a list of all hospital staff who could speak additional languages. If a patient required an interpreter, staff told us they would check the list of hospital staff first and if a member of staff who spoke the patient’s language was available, they would usually attend the department as a translator. In the event of there being no staff available who spoke the patient’s language, staff had access to a telephone translation service. This allowed staff to communicate with the patient via a three-way conversation with a remote translator.

Staff told us language signers were available within the hospital and explained they could request this support when required.

Staff gave patients a choice of food and drink to meet their cultural and religious preferences. Water was available throughout all outpatient clinics and waiting rooms. Although the service did not routinely provide food within the clinics, patients and relatives could purchase refreshments from several retail outlets and cafés within the hospital.

Staff had access to communication aids to help patients become partners in their care and treatment. We spoke with staff in the ear, nose and throat (ENT) department, who told us staff had access to several visual communication cards and aids to support patients with more complex communication needs.

**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.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The NHS Operating Framework and NHS Constitution states that all patients have a right to start consultant-led treatment within a maximum of 18 weeks from the referral date. Data supplied by the trust showed from April 2018 to March 2019, the trust’s performance for the 18-week referral to treatment (RTT) indicator was consistently better than the England average.

For all 13 individual specialities provided, the trust performed better in every speciality compared to the England average. The highest performing speciality was neurology, where the trust achieved the 18-week RTT in 98.8% of referrals compared to an England average of 77.4%. The lowest performing speciality in the department was ophthalmology, where the trust achieved the 18-week RTT in 94.9% of referrals. However, this was still better than the England average of 88.5%.

For the most recent reporting period of March 2019, the trust achieved an overall RTT across all specialities of 97.7%, which was higher than the England average of 87.1% for the same period.

Staff and managers from the dermatology service told us how they had found it challenging at times to keep waiting lists and times to a minimum. They told us this was due to both a national demand for dermatology services, combined with two of the hospital’s neighbouring NHS acute trusts limiting the number of new dermatology patients to their services, which had increased the demand for this trust’s services. However, staff told us they continued to accept all referred patients, and prioritised patients with two-week cancer appointments to ensure the service met its target. Staff told us they discussed waiting lists and times at weekly patient tracking list (PTL) meetings, which the trust held across all specialities.
We spoke with divisional and departmental managers around management of RTT. They explained how the service had robust governance processes in place to manage patient waiting lists and referral performance. They explained how managers met weekly to discuss PTLs across all specialities and how the trust’s chief operating officer (COO) held divisions to account on a weekly basis for their RTT performance. Managers told us they created and implemented a rapid action plan for any service that dropped below 90% on their 18-week RTT performance. Managers explained how the service had developed several data and business intelligence (BI) improvement programmes, which helped them to monitor the performance and effectiveness of their service. They explained how they had recently educated and supported staff over the importance of accurate data input in all systems, which allowed the service to collect and collate data they had never collected before. The service could then analyse this data to determine potential service improvements or areas of additional focus.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From April 2018 to March 2019, the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently better than the England overall performance.

The latest figures for March 2019 showed 97.7% of this group of patients received treatment within 18 weeks versus the England average of 87.1%.

From April 2018 to March 2019, the range at the trust was 97.6% to 98.4%; the England range was 87.8 to 89.1%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, James Paget University Hospitals NHS Foundation Trust**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

From April 2018 to March 2019, 13 specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).
### Specialty grouping  
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>98.8%</td>
<td>77.4%</td>
</tr>
<tr>
<td>Other</td>
<td>98.7%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>98.6%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.4%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>98.0%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>97.7%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>97.4%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>96.6%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>96.6%</td>
<td>90.2%</td>
</tr>
<tr>
<td>General medicine</td>
<td>96.5%</td>
<td>90.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>96.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>95.3%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>94.9%</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

*Source: NHS England*

### Referral to treatment (percentage within 18 weeks) – incomplete pathways

From April 2018 to March 2019, the trust’s referral to treatment time (RTT) for incomplete pathways was similar to the England overall performance.

The latest figures for March 2019, showed 84.4% of this group of patients received treatment within 18 weeks versus the England average of 86.3%.

### Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, James Paget University Hospitals NHS Foundation Trust.

*Source: NHS England*
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

From April 2018 to March 2019, 14 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>Cardiothoracic surgery</td>
<td>100.0%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>100.0%</td>
<td>82.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>96.8%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>96.1%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Other</td>
<td>95.8%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.6%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>94.8%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>94.4%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>93.8%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>92.3%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>91.7%</td>
<td>86.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>90.0%</td>
<td>89.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>89.6%</td>
<td>83.7%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>89.5%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

Four specialties were 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>Geriatric medicine</td>
<td>92.3%</td>
<td>95.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>91.7%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>77.8%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>67.4%</td>
<td>81.3%</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 seen within two weeks of an urgent GP referral from 2018/19 quarter 1 to quarter 4 (April 2018 to March 2019). The performance over time is in the graph below.
Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) from 2018/19 quarter 1 to quarter 4 (April 2018 to March 2019). The performance over time is in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), James Paget University Hospitals NHS Foundation Trust

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed worse than the 85% operational standard and similar to the England average for patients receiving their first treatment within 62 days of an urgent GP referral in 2018/19 quarters 1 and 2 (April to September 2018). However, performance improved to be in line with the standard, and above the England average, in 2018/19 quarters 3 and 4 (October 2018 to March 2019). The performance over time is in the graph below.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, James Paget University Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Managers worked to keep the number of cancelled appointments to a minimum. All staff we spoke with from across outpatient services told us managers rarely cancelled clinics, and they were not aware of managers or doctors cancelling any clinics because of nursing staffing. Managers told us there was a strict rule that the service should not cancel clinics within six weeks’ notice. If the service had staff shortages, clinicians usually arranged cover from within their own team to ensure clinics continued to run.

We spoke with staff from the department of medicine, who explained if managers or doctors cancelled a clinic within six weeks’ notice, they would reschedule the clinic to another day that week. This helped to ensure the service did not extend patient waiting times.

When patients had their appointments cancelled at the last minute, managers made sure they rearranged these as soon as possible and within national targets and guidance. Managers told us in the event of a cancellation of a patient’s appointment, they would reschedule clinics as close to the patient’s allocated appointment as possible. For example, they explained how recently they cancelled an ear, nose and throat (ENT) clinic, due to the doctor attending a patient requiring emergency treatment. Managers explained they had rescheduled several of the appointments for later that day, or for other days in that week.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff and managers told us most outpatient clinics started and ran on time, which ensured patients did not stay longer than required. In the event of a delay, staff explained they communicated this to patients to keep them informed. For example, if a delay was over 30 minutes, staff made verbal announcements to all patients in the waiting room. They also updated clinic whiteboards with the current anticipated delay.

Staff supported patients when doctors referred or transferred them between services. For example, staff in the oncology and breast care unit worked closely with other outpatient services and hospital departments. Staff explained that although the clinics were nurse and consultant led, they worked closely with outpatient nurses to support patients, particularly around post-diagnosis 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. However, the service did not always resolve complaints within specified timescales.

Patients, relatives and carers knew how to complain or raise concerns. During our inspection, we spoke with patients and their relatives, who told us they were aware of how to raise a complaint if required.

Staff understood the policy on complaints and knew how to acknowledge and handle them, however the service did not always resolve complaints within specified timescales. Staff and managers across outpatient services knew and understood how to manage a patient complaint. For example, managers from the pathology service explained how they would initially try to resolve any patient dissatisfaction whilst the patient was in the clinic. If this was unsuccessful or if the patient declined, staff would provide the patient with information on the trust’s patient advice and liaison service (PALS), either by a face-to-face meeting with the PALS team, or via an information leaflet. This service provided patients with a point of contact where they could feedback on the care they had received. Staff told us they helped patients through the trust’s complaints procedures and provided them with the advice and help when needed.

**Summary of complaints**

From June 2018 to May 2019, the trust received 32 complaints in relation to outpatients (14.3% of the total complaints received by the trust). The most common subject of the complaints was all aspects of clinical treatment (13).

A breakdown of complaints by subject is below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects clinical treatment</td>
<td>13</td>
</tr>
<tr>
<td>Communications</td>
<td>5</td>
</tr>
<tr>
<td>Appointments</td>
<td>5</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>5</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1</td>
</tr>
<tr>
<td>Privacy, dignity &amp; wellbeing</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

For the 19 complaints the trust had closed at the time of data submission, the trust took an average of 85.9 working days to investigate and close them. This is not in line with their complaints policy, which states the trust should close complaints within 60 working days.

The 13 complaints not yet closed had been open for an average of 100.5 working days at the time of data submission.

However, we noted in data supplied by the trust prior to inspection in their routine provider information request (RPIR), the trust reported they had resolved 100% of complaints within 60 working days. We raised this conflicting information with managers whilst on inspection, who advised there had been significant staffing changes within the PALS and complaints teams, which may have impacted on data quality.

Following our inspection, we requested further data from the trust regarding complaint resolution timescales. This data confirmed the trust had received 22 complaints for outpatient services.
between September 2018 and August 2019. Of these 22 complaints, the service had resolved 12, with 10 still awaiting a response. However, for the complaints that service had resolved, the average time to respond was 83 days. The shortest time was 13 days, with the longest being 215 days.

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

Managers investigated complaints and identified themes. We spoke with managers from across outpatient services, who told us how they investigated complaints within the service. Managers explained the trust’s patient advice and liaison service (PALS) received the complaint and forwarded this to the appropriate manager for investigation. If required, the PALS team requested information from staff, such as statements and documentation, usually within strict timeframes to facilitate a prompt response.

Patients received feedback from managers after the investigation into their complaint. Once managers had investigated the patient’s complaint, the service wrote the patient a resolution letter, which the chief executive officer (CEO) reviewed and approved.

We reviewed three completed complaint investigations and accompanying resolution letters. We saw these were comprehensive and covered all points raised in the patient’s complaint. Each resolution letter contained details of how the patient and/or relative could escalate their complaint to the parliamentary and health service ombudsman (PHSO) if they were not happy with the trust’s initial response. However, we saw the trust had apologised in one of the complaint letters due to the delay in their response, which had exceeded their timescales. We saw the trust had attributed this to limited availability of a key member of clinical staff.

Managers shared feedback from complaints with staff and ensured they used any learnings improve the service. Managers told us they monitored all complaints and discussed any emerging themes and concerns. Managers explained whilst the service reviewed complaints at a divisional level, the service shared any learnings with staff cross-divisionally at monthly divisional meetings.

In the three complaint resolution letters we reviewed, we saw the service detailed how it may use the complaint for discussion at a future board meeting. In addition, we saw how the trust had sent the resolution letter to the patient, as well as to several departments and clinicians, including to both divisions, registrars, consultants, clinical lead nurses and senior sisters.

Number of compliments made to the trust

From May 2018 to April 2019, there were 27 compliments received for outpatients (3.5% of all compliments received trust wide).

The service received compliments in nine of the 12 months of this period. September 2018 was the month where they received the most compliments (7).

The trust did not provide a breakdown by subject for compliments received.

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

Is the service well-led?

Leadership

Leaders had the integrity, 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 trust managed outpatient services under both the division of medicine and the division of surgery. A divisional operations director, divisional operations manager and a matron managed each respective division. Each outpatient clinic operated with a team of nurses, healthcare assistants and reception staff, which a dedicated sister or senior nurse for that specialism managed.

We spoke with the divisional and leadership teams for outpatients, who understood and managed the issues the service faced. For example, managers were aware of the challenges around capacity and patient demand for certain services, such as dermatology, and had developed plans to manage these concerns, such as through evening and weekend clinics.

Staff from across outpatient services spoke with high regard to their local and divisional leadership teams. Staff told us how their leaders and managers, including the chief executive officer (CEO), were approachable and visible and that staff had no concerns in raising any concerns to them.

Leaders and managers encouraged their staff to develop their professional skills and take on more advanced roles. All staff received appraisals, during which staff and managers could discuss any development goals or ambitions. Managers told us how they were upskilling staff to work across several different outpatient services, both to enhance and develop individual staff skills, as well as building a better staffing resilience to the service. Managers worked with other organisations and healthcare providers to facilitate staff development. For example, the service arranged for staff to work with staff from neighbouring hospitals to gain ideas and to share knowledge and experience. Staff could develop their professional skills through specialist courses arranged by the service, such as through NHS Improving Quality (NHS IQ) data courses.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The trust had developed a ‘Five Year Trust Strategy for 2018 – 2023’, which encompassed three separate strategies; their ‘Quality and Improvement Strategy’, ‘Clinical Strategy’ and ‘5 Year People Strategy’. To support achievement, the trust had developed four strategic ambitions. These four ambitions included an aim to ‘deliver the best possible level of safe and effective care’, to ‘provide education, support and development for [their] staff to deliver excellence in practice and be the employer of choice’, to ‘effectively manage [their] resources, [their] estate and [their] infrastructure to ensure [they] are sustainable’, and to ‘actively participate in innovations, research and partnerships to transform [the trust’s] services’.

The trust had developed a clinical strategy, in which it detailed its future aspirations for clinical services. In this strategy, the trust described how its future goal was to enhance the accessibility and capacity of their ophthalmology outpatient services, and how they planned to work with regional partners to increase the provisions of their trauma and orthopaedic services.

We spoke with managers from across outpatient services regarding their vision and aspirations for the service. They explained how they were working towards developing a dedicated ‘outpatients’ village’ for the trust, which aimed to be a purpose-built development to house all outpatient clinics and services. Although this was still in planning at the time of our inspection, staff and managers were passionate about these proposals and explained how it would facilitate better patient experiences.
Culture

Staff felt respected, supported and valued. Staff 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.

Managers and staff from across outpatient services explained how they ensured the patient was always their priority and always received the best care possible. Staff told us how they felt valued and respected by their colleagues and managers, and how they found the trust to be an enjoyable place to work. Several staff we spoke with had worked for the trust for significant time and had continued to work for the trust after retirement on a casual or bank staff basis. One member of staff told us the hospital was a “really lovely place to work”. Another staff member told us how the trust was a “good place to work”, and that staff were “very friendly”.

During our inspection, we found there was an open culture across outpatient services. Staff spoke with high regard to their leaders and managers. Staff told us managers were open and approachable, and staff felt comfortable to raise any concerns or issues to them without fear.

We spoke to the divisional leadership team, who told us the culture had changed across the organisation, as staff now regularly worked across all outpatient areas. They explained that, although this had initially caused some anxiety, staff now accepted this and saw it gave them further opportunities for career development.

Both staff and managers told us they felt valued to work for the trust. The service had launched several staff recognition schemes to reward staff achievements. This included the ‘James Paget Remarkable People Awards’, where managers recognised teams and individuals for their exceptional service. Managers told us of an informal scheme called ‘You’ve Been Mugged’, whereby staff could recognise a fellow colleague’s work by presenting them with a mug filled with chocolates and sweets. Staff could then refill this and pass it on to another staff member.

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 trust governed outpatient services under divisional boards for both medicine and surgery. These divisional boards fed into one of 11 sub-committees, including the transformation board, patient safety and effectiveness committee, and safeguarding committee. These sub-committees fed into five overall committees, including the audit committee and finance and performance committee. These ultimately fed into the board of directors and the council of governors.

There were governance processes in place to manage patient waiting lists and referral performance. For example, managers explained how they met weekly to discuss patient tracking lists (PTLs) across all specialties. Each division managed their referral to treatment (RTT) performance; however, the chief operating officer (COO) oversaw this and held each division to account on a weekly basis for their RTT performance.

Staff and managers understood their individual roles and responsibilities and knew what they were directly accountable for. Both staff and managers of all levels had regular opportunities to meet
and discuss the department, as well as the wider hospital. For example, staff in the ear, nose and throat (ENT) department explained how managers held quarterly meetings for all staff to attend.

Managers met regularly to discuss the service in cross-divisional meetings. This included monthly clinical leadership meetings and monthly specialty meetings. Staff explained how managers circulated meeting agendas prior to any meeting, which allowed them to add items for discussion. After each meeting, managers sent all staff any meeting minutes and any agreed actions.

We reviewed the minutes for several meetings which concerned outpatient services, including the orthopaedic governance meeting minutes from May 2019, ophthalmology consultant business meeting minutes from July 2019 and the surgical business meeting minutes dated March 2019. We saw the minutes provided a detailed account of what managers discussed. We saw how staff, managers and clinicians from various roles attended and discussed several topics including governance, risks and departmental updates.

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.

Both local and divisional leadership teams managed and monitored departmental performance. Managers undertook audits across outpatient services, which included hand hygiene audits, ‘making a difference’ audits, health and safety audits, medicine management audits and internal quality review audits. Managers discussed and shared audit results with staff and took actions to improve quality.

The trust operated a central risk register, which detailed all risks affecting the trust. Staff and managers could put forward suggested risks for inclusion on the register. The trust reviewed and investigated all suggested risks and updated the register accordingly.

We reviewed the entries for outpatient services from the register dated June 2019 and saw there were four active risks for outpatients. These included the sustainability of the trust’s ear, nose and throat (ENT) on-call arrangements, concerns over the standards of the trust’s East Point Consulting Rooms (EPCR), the age of the trust’s field analysers and capacity constraints within the ophthalmology department. We saw how the service had graded each risk dependent on its severity and had included an ‘aim risk’ as the target end risk for each entry. We saw managers entered regular updates and progress notes next to each entry, along with a date of next review. At the time of our review, we saw all four risks were within any specified review dates.

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 service had integrated and secure information systems. The service submitted data or notifications consistently to external organisations as required.

Service managers told us they had developed in data management and business intelligence (BI) tools, with an overall goal of using data more intelligently. Managers had recently created a dedicated trust access manager role, who liaised between managers and the trust’s data and informatics team to help create innovative and bespoke data reports.
Managers explained the service had recently gone through an extensive education and awareness programme with clerical and administration staff around the importance of accurate data input. This resulted in managers developing an in-house competency programme for clerical staff, combined with training packages provided by NHS England’s NHS Information Quality (NHS IQ) team.

Following the education programme, managers could review and analyse data the service had not collected before, which they used to identify potential improvements to service delivery. Managers shared and reported this data with external stakeholder organisations.

**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 actively engaged with patients and the wider public to support patient care. For example, managers told us new patient focus groups had been set up to support patients with specialist conditions, such as stoma care. The service discussed feedback and suggestions from these groups at divisional and board level. Staff also met with representatives from equality and community groups to help patients from these user groups access services effectively.

Managers regularly engaged with external stakeholders and healthcare providers, including primary care services and NHS organisations, to support patient care. For example, the service had developed arrangements for staff to work at a nearby NHS hospital to gain ideas and to share knowledge and experience.

Staff told us how most departments had set up dedicated ‘away days’ for staff, both to support training events and for social occasions.

**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.**

Both staff and managers were passionate about continuous improvement and new ways of working. We saw how the service participated in several new initiatives and research programmes aimed at enhancing patient care and experiences. For example, staff explained how the ophthalmology service was currently participating in nine research projects, which included national clinical projects.

Managers explained how they had developed the service to meet changing patient demands, such as through increased evening and weekend clinics for high demand services, such as dermatology, endoscopy and neurology. Managers were trialling virtual and telephone clinics to allow the service to see patients quicker or whilst at home, particularly for clinics whereby doctors viewed and assessed test image results.

The trust was developing new services, including a specialist electrophysiology clinic for the assessment and treatment of patients with cardiac arrhythmias.

The service had focussed on pathway redesign across outpatient services, to ensure patients received a streamline service and did not have to wait longer than necessary.