Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

We found areas where significant improvements had been made:

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

Summary of findings

- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital. Parents were aware that some children and young people with mental health conditions being cared for on the ward at times and told us they felt their child was 'safe' on Skylark ward.
- There was a clear focus on patient safety, effective risk assessment and management throughout the children and young people's service, which were owned by all staff.
- Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions. Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.
- Risk assessments for children and young people with mental health issues had significantly improved as had staff access and uptake of mental health and conflict resolution training.
- Staff were able to demonstrate their competence in caring for children and young people with mental health issues and care was planned and delivered in line with evidence-based guidance.
- Procedures and guidance available to staff was comprehensive and up-to-date. Staff were able to respond appropriately to internal security arrangements that kept children and young people safe.
- The service risk register reflected the risks associated with the children and the adolescents mental health service (CAMHS) patients and children experiencing self-harm behaviour and was reviewed and updated as required. Nursing audits were monitoring care provided against expected standards.
- There were positive relationships with the CAMHS who were open and responsive to the needs of children with mental health needs on Skylark ward.
- The total number of patients waiting over 52 weeks for their treatment on the admitted and non-admitted referral to treatment (RTT) pathways had improved. This had reduced from 413 to 182 patients waiting.
- Where things had gone wrong, duty of candour was maintained.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete RTT pathways for high-risk specialties.
- There was oversight on the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.
- Managers in the service had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- The trust had recruited its own team of data validators.

However, we also found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival to the ED from April 2016 to March 2017. The performance was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.
- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not yet meeting national guidance for 95% of patients to be seen within 15 minutes of the time. However, during our inspection, all patients received an initial clinical assessment within 15 minutes.
- The computer system the department used for triaging patients and capturing data was to be improved, so that the first set of clinical observations could be recorded. This would improve data collection and overall monitoring of this performance measure in the ED.
- The trust was planning to carry out harm reviews on those patients who had died whilst on a waiting list.

Summary of findings

- The number of patients waiting for 31 weeks on an RTT pathway had increased from 9% to 27%. Managers were making plans to address this increase.

We found an area of outstanding practice:

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

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

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

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		As we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question or this core service overall. We found areas where significant improvements had been made: • Patient privacy and dignity were respected at all times whilst patients were being cared for within the emergency department. • A designated mental health assessment room was available which complied with national guidance. • Risk assessments and triage tools were used for patients with mental health concerns, ensuring they were cared for with the correct level of observation in a safe, risk-assessed area. • Patients arriving by ambulance or self-presenting to emergency department (ED) reception generally received a timely initial time to clinical assessment. • There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance. Safeguarding level three children training figures were now above the trust's target of 90% for both nurses and doctors in the ED. • The paediatric emergency department was staffed with two registered nurses at all times. One of these would be a registered nurse (child branch), if not, there were processes in place to mitigate the risk to ensure paediatric competent nurses were on duty. • The paediatric emergency department was now kept secure, with staff ID badge 'swipe' access only. • Staff training in paediatric competencies had significantly improved since the last inspection. • The leaders of the ED had made significant progress to improve and address all areas of the warning notice. • Effective risk management processes were now in place, embedded and monitored. • Staff at all levels were aware of the concern raised at the last inspection and were involved in driving improvement in ED to address these concerns. • Staff felt that communication from the trust wide team down to the leaders of ED had improved.

Summary of findings

- 'Black breaches' were now reported formally at the trust board. Performance was monitored and used to drive improvements. All staff could explain what a 'black breach' was.

However, we also found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival in the ED. In the period April 2016 to March 2017 performance was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.
- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not yet meeting national guidance for 95% of patients to be seen within 15 minutes of the arrival time. However, during our inspection, all patients had an initial clinical assessment within 15 minutes.

Services for children and young people

As we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question or this core service overall.
We found areas where significant improvements had been made:

- The clinical leadership provided by the paediatric lead nurse had been instrumental in the provision and maintenance of a safe and secure environment for children on Skylark ward.
- There was a clear focus on patient safety, effective risk assessment, and management throughout the service which were owned by all staff.
- Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions.
- Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.
- Risk assessments for children and young people with mental health issues had significantly improved as had staff access and uptake of mental health and conflict resolution training.

Summary of findings

- Staff were able to demonstrate their competence in caring for children and young people with mental health issues and care was planned and delivered in line with evidence-based guidance.
- Procedures and guidance available to staff was comprehensive and up-to-date and staff were able to respond appropriately to internal security arrangements that kept children and young people safe.
- There was an effective system for identifying, capturing, and managing risks and issues at team and directorate level. The service risk register reflected the risks associated with the children and the adolescents mental health service (CAMHS) patients and children experiencing self-harm behaviour. This was reviewed and updated as required.
- Nursing audits were monitoring care provided against expected standards.
- There were positive relationships with the CAMHS who were open and responsive to the needs of children with mental health needs on Skylark ward.
- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital. Parents were aware that some children and young people with mental health conditions were being cared for on the ward at times and told us they felt their child was 'safe' on Skylark ward.

However, we found that:

- There were 'blind spots' in the CCTV coverage on Skylark ward. The trust took immediate action to address this once we had raised it as a concern.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff allowing other people to follow them into and out of the ward unchallenged. The trust took immediate action to address this once we had raised it as a concern.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were inappropriately placed on Skylark ward, as there were no other appropriate placements available in the community. Whilst this was a system wide issue, this posed a pressure to staff and patients on the ward. This was reflective of system-wide pressures across the health economy.

Summary of findings

Outpatients and diagnostic imaging

As we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question or this core service overall.
We found that:

- The total number of patients waiting over 52 weeks for their treatment on the admitted and non-admitted pathways had improved. This had reduced from 413 to 182 patients waiting.
- Where things had gone wrong, duty of candour was maintained. This was evidenced in the medical notes of patients who had suffered moderate harm as a result of waiting for treatment.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust also had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete RTT pathways for high-risk specialties.
- There was oversight of the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.
- Managers in the service now had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen.
- This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- The trust had recruited its own team of data validators.

However, we also found that:

Summary of findings

- The trust was planning to carry out harm reviews on those patients who had passed away whilst on a waiting list.
- The number of patients waiting for 31 weeks on an RTT pathway had increased from 9% to 27%. Managers were making plans to address this increase.

Kettering General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Services for children and young people and Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Kettering General Hospital

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

There are approximately 613 inpatient beds and over 3,200 whole time equivalent staff are employed. All acute services are provided at Kettering Hospital with outpatients' services also being provided at Nene Park, Corby Diagnostic Centre, and Isebrook Hospital. The findings in this report do not reflect the three sites that we did not inspect: Nene Park, Corby diagnostic centre and Isebrook outpatients.

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

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

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

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

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

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

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Kettering General Hospital NHS Foundation Trust and from information provided by other stakeholders.

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

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

We inspected part of the urgent and emergency care service, children and young people's service and outpatients. We also looked at the governance and risk management systems across the hospital and at board level. As we only inspected parts of the five questions (safe, effective, caring, responsive and well led), we have not rated any key question, or any service, or the trust overall, at this inspection.

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

Facts and data about Kettering General Hospital

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

The hospital serves a population of around 320,000.

In 2015/16 the hospital had:

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

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

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department (ED) at Kettering General Hospital provides a 24 hour, seven day a week service for a population of approximately 320,000 people across North Northamptonshire and South Leicestershire.

The main ED consists of 13 bays for patients within majors, six treatment areas for patients within minors, resuscitation spaces for up to five patients and six areas in the emergency decisions unit (EDU).

The department has its own children's ED with a separate waiting area, three cubicles, and an assessment area.

Patients present to the department either by walking into the reception area or arriving by ambulance through a dedicated ambulance-only entrance. Patients who transport themselves to the department report to the reception area where they are assessed and streamed to either the minors or the majors areas.

From April 2015 to March 2016, there were 82,986 ED attendances: 17,077 of these attendances were children aged 0 to 17 years.

During this inspection, we spoke with 15 members of staff, eight patients and three ambulance crews. We reviewed 35 sets of patient's records.

Summary of findings

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

We found areas where significant improvements had been made:

- Patient privacy and dignity were respected at all times whilst patients were being cared for within the main department.
- A designated mental health assessment room was available which complied with national guidance.
- Risk assessments and triage tools were used for patients with mental health concerns, ensuring they were cared for with the correct level of observation in a safe, risk-assessed area.
- Patients arriving by ambulance or self-presenting to ED reception received a timely initial time to clinical assessment.
- There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance. Safeguarding level three children training figures were now above the trust's target of 90% for both nurses and doctors.
- The paediatric emergency department was staffed with two registered nurses at all times. One of these would be a registered nurse (child branch), if not, there were processes in place to mitigate the risk to ensure paediatric competent nurses were on duty.
- The paediatric emergency department was now kept secure, with staff identity badge 'swipe' access only.
- Staff training in paediatric competencies had significantly improved since the last inspection.

Urgent and emergency services

Training compliance had improved since the recruitment of a practice development nurse, who was now monitoring compliance and performance in this area.
- The leaders of the ED had made significant progress to improve and address all areas of the warning notice.
- Effective risk management processes were now in place, embedded and monitored.
- Staff at all levels were aware of the concern raised at the last inspection and were involved in driving improvement in ED to address these concerns.
- Staff felt that communication from the trust wide team down the leads of ED had improved.
- 'Black breaches' were now reported formally at the trust Board and performance monitored and used to drive improvements. All staff could explain what a 'black breach' was.
- Staff showed care and compassion towards patients and their families. Patients told us they had been treated with kindness, dignity, and respect.

However, we also found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival to the ED. From April 2016 to March 2017 performance was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.
- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not yet meeting national guidance for 95% of patients seen within 15 minutes of the arrival time. However, during our inspection, all patients had had an initial clinical assessment within 15 minutes of arrival.
- The computer system the department used for triaging patients and capturing data was to be improved, so that the first set of clinical observations could be recorded. This would improve data collection and overall monitoring of this performance measure in the ED.

Are urgent and emergency services safe?

As we only inspected parts of this key question, we have not rated it.

We found areas where significant improvements had been made:

- A designated mental health assessment room was available which complied with national guidance.
- Risk assessments and triage tools were used for patients with mental health concerns, ensuring they were cared for with the correct level of observation in a safe, risk-assessed area.
- Patients arriving by ambulance or self-presenting to ED reception received a timely initial clinical assessment.
- There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance.
- Safeguarding level three children's training figures were now above the trust's target of 90% for both nurses and doctors.
- The paediatric emergency department was staffed with two registered nurses at all times. One of these would be a registered nurse (child branch), if not, there were processes in place to mitigate the risk to ensure paediatric competent nurses were on duty.
- The paediatric emergency department was now kept secure, with staff identiity badge 'swipe' access only.

However, we also found that:

- Although the time to initial clinical assessment had significantly improved and effective systems were in place, the ED was not yet meeting national guidance for 95% of patients to be seen within 15 minutes of the arrival time. However, during our inspection, all patients received an initial clinical assessment within 15 minutes of arrival.
- The computer system the department used for triaging patients and capturing data was to be improved, so that the first set of clinical observations could be recorded. This would improve their data collection and overall monitoring of this performance measure in the ED.

Incidents

- We did not inspect this element.

Cleanliness, infection control and hygiene

- We did not inspect this element.

Environment and equipment

- At the last inspection in October 2016, we were not assured that adults or children presenting to the emergency department (ED) with mental health conditions, who were at risk to themselves or others were being cared for in a safe or appropriate environment. The ED had no designated room for patients presenting with mental health conditions in line with Royal College of Emergency Medicine (RCEM) guidelines. The mental health risk assessment tool in use at the time of our inspection did not take into account all environmental and physical risks.
- Following our escalation of this risk, that the service had not fully recognised, the trust provided us with updated guidance and risk assessments tools for all patients presenting with mental health conditions which included assessment of possible environmental risks. This included an environmental hazards checklist and clear flow chart that described the actions required by staff and level of care required for individual patients based on the risk assessment score. This assessment tool was to be reviewed daily and included in the two hourly safety rounds in the ED. The trust told us that the departmental lead nurse was undertaking spot checks on compliance with completion and that the mental health assessment room was checked regularly throughout each shift.
- On this inspection, we reviewed the ED's mental health assessment room. We found it to be compliant with national guidance. Senior leaders in ED had worked in partnership with another local NHS trust to develop the correct assessment tools and the redesign of the room. The clinical lead from the Royal College of Psychiatrists had also visited to risk assess the room and found it met all national standards.
- The mental health assessment room was still on the service's risk register as a moderate risk. Further work was needed so that the panic alarm button would be made flush with the wall. However, a risk assessment was in place for this specific risk and the button would break off the wall if anything over 10 kilograms was hung from it. Therefore, the ligature risk was minimal whilst they were waiting for new flush panic alarms. Staff told us that no patients would be left unattended in this room.
- We visited the mental health assessment room at different times of the day and on three separate days during the inspection. During each 'spot check', we found it to be used as documented in their mental health assessment tool and risk assessment, which included an environment hazard check. It was not used as an extra capacity room when the department was busy and was specifically for assessment of patients presenting with mental health concerns. The design, maintenance, and use of facilities and premises met patients' needs.
- On the first day of our inspection, we found that the ED's extra capacity room, called the 'Red' area, was not secured when not in use. There was a potential risk that this area could be accessed by patients or visitors who could have access to the equipment in this room. We raised this with the trust, who took immediate action to install a card swipe mechanism so that the room could only be entered by staff. We checked this room on the third day of our visit and the room was secured appropriately when not being used.

Medicines

- We did not inspect this element.

Records

- We did not inspect this element.

Safeguarding

- At the last inspection in October 2016, there were not effective systems and processes in place to ensure that patients were protected from the risk of abuse. We were not assured that all staff were aware of the processes or received the required training. The ED had a process for identifying and managing patients at risk of abuse; however, we were not assured that all staff were following it. During that inspection, we looked at 33 sets of patient records and found that in eight instances the safeguarding process was not always completed in line with the hospital policy or national guidelines. We also found that nursing staff compliance with safeguarding level three was 18% and that medical staff compliance was 29% against a hospital target of 85%.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' (RCPCH, 2014) provides guidance on levels of safeguarding training for different groups. The document states that 'All clinical staff working with children, young people

and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three'.

- We highlighted our urgent concerns to the trust regarding the level of safeguarding training and the lack of compliance with the hospital's protocols regarding safeguarding. The trust immediately put in an action plan to address the training needs and we were supplied with updated data on 31 October 2016 that showed that 37% of nursing staff had completed safeguarding level three and there were planned training days throughout November 2016. We also saw that the trust had arranged for bespoke training sessions for staff in ED, which were to be delivered by the clinical lead for safeguarding. The trust told us that they would be conducting regular monthly audits and all safeguarding referrals would continue to be checked on a daily basis by a designated staff member of ED.
- During this inspection, we viewed the ED staff's level three safeguarding children's training figures and spoke with the nursing and clinical leads for the emergency department. We found there to be a significant improvement since the last inspection, and had completed the actions documented to address the concerns we had raised. There were clear systems in place to safeguard vulnerable children. The safeguarding policy now reflected national guidance.
- Training figures for level three safeguarding from November 2016 to May 2017 for nursing staff showed at 92% compliance and medical staff were 93% compliant, which was better than the trust's target of 90%.
- We checked records for 10 patients and found safeguarding referrals carried out as stated in their policy. There was a specific page dedicated to safeguarding in the patients records and on the trust IT system. However, staff told us sometimes there were delays out of hours in getting a social worker to reply to an urgent referral. Staff reviewed all new attendances by children to the ED within 24 hours and informed the relevant authorities and GPs when required.
- The ED had also advertised for a paediatric liaison facilitator with this new staff member due to commence the role in late June 2017.
- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse. All staff were clear about their responsibilities and were able to tell us the indications of suspected abuse, for both adults and children.

Mandatory training

- We did not inspect this element.

Assessing and responding to patient risk

- During the last inspection, we found concerns regarding a number of issues about assessing and responding the risk to patients.

Mental health assessment room

- During the last inspection, we found concerns about the ED process for risk assessment of patients presenting with mental health conditions. During this inspection, we reviewed the mental health assessment tool and spoke with staff. Patients who presented with a mental health concern were triaged using the newly developed mental health risk assessment triage tool. This determined what level of observation was required and the actions to follow. It also included an environment checklist tool and what steps to take if the mental health assessment room was in use to keep the patient safe until it was available.
- We looked at 10 patient records who presented with a mental health concern and all 10 patients had a fully completed triage assessment. The actions were followed and documented. Training in the use of the mental health triage assessment tool had been carried out with all staff.
- There were contingency plans when the mental health assessment room was in use. We asked staff and they all knew the plan and the area that was used: this area had been risk assessed.
- The ED also had a separate mental health triage assessment tool for children presenting with mental health concerns. We looked at five sets of records for children and found the triage tool to have been completed fully.
- We observed the ED's two hourly safety round and the mental health assessment room. Patients' needs were discussed during this safety round and documented.

- Since the redesign of the mental health assessment room and implementation of the assessment triage tool, there had been no reported incidents of patients absconding.

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

- The Department of Health recommends that ambulance handovers be completed within 15 minutes of arrival at the ED to ensure that an initial clinical assessment is carried out in a timely manner. In our October 2016 inspection, we found that from April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 mins and 323 'black breaches'. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust had reported 'nil' black breaches in the 12 months August 2015 to July 2016 as it had not understood the definition of a 'black breach'. From speaking with staff in the department, we established that there were daily 'black breaches' but staff were not able to provide detailed information regarding this. Senior managers told us they thought a 'black breach' was defined as a patients waiting over 12 hours on a trolley in the ED.
- The ED had a dedicated ambulance streaming area with three bays. This had been introduced in February 2016. The ED escalation policy was to provide clear actions and directions to manage periods of high demand, which all staff should have been fully aware of. This included opening up an extra area to avoid patients waiting in the corridor. During the last inspection, we found that not all senior medical staff in charge of ED were able to articulate this ED policy and the department did not always have the capacity to staff the area when it was necessary. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The hospital performed better than the 60 minute time to treatment standard between June 2015 and January 2016. From January 2016 to May 2016, performance against this standard showed a varying trend around and similar to the standard.
- After our October 2016 inspection, the trust provided us with clarification that the original omission of 'black breach' information was due to confusion surrounding the use of 'black breach' terminology to identify patients who were cared for in the emergency department for 12 hours or more for which they had 'nil' in the past 12 months. The trust had updated the 'ambulance streaming' policy to include a clear escalation process for patients 'queuing in' and awaiting ambulance handover.
- On this inspection, all 'black breaches' were now formally reported to the trust board and all staff were aware of the definition of a 'black breach'. We saw that there were posters in the department saying how many 'black breaches' they had had for the month. For May 2017, there had been 75, which was lower than the previous month.
- From March 2017 to May 2017, the ED had 8,143 ambulance arrivals and 4,410 of these patients had a clinical handover within 15 minutes. 260 of these ambulance arrivals breached the 60 minutes performance measure. These were reported formally as 'black breaches'. The senior leaders for ED told us they knew they were still on their journey of improvement.
- We looked at five sets of records for patients that had been recorded as a' black breach'. These patients had not been formally handed over to the ED staff, as were still on an ambulance trolley with the ambulance crew. We saw that each patient had had a set of initial observations, or that a nurse/doctor had seen them whilst they were waiting to be handed over to the ED staff. This assured us that patients, even though waiting 60 minutes or over to be handed over, were still safe whilst they were waiting and their needs were being met.
- The ED had implemented a new ambulance streaming operating procedure, with a clear pathway for ambulance arrivals and now had an ambulance streaming assessment area of four trolley bays. This had increased from the three trolley spaces at the last inspection.
- During the days of our inspection, all patients that arrived by ambulance were able to be handed over to ED staff and have an initial clinical assessment carried out within 15 minutes. We visited the ED unannounced from 9pm to 10.30pm on one night and found that there were two ambulance crews waiting to handover their patients into the ED streaming area. The patients had been assessed by one of the senior nurses working in the ED streaming area and had been assessed as safe to wait until a trolley in ED was free.

- Staff said there were occasions when ambulances arrived and could not handover patients promptly. As part of the ED escalation process, which was detailed in the operating procedure policy, a room called the 'Red' area was opened as an 'overflow' area. This was only opened when ED staffing levels allowed. The lead nurse told us that if it was needed to be opened they would ensure extra staff were booked through agency for this area. During our inspection, we did not see this area in use as it was not needed. We saw agency induction processes were in place.
- When the department had delayed ambulance handovers from 30 to 60 minutes, the hospital ambulance liaison officer (HALO) received the patient handovers so that the ambulance crews could be released. The nurse in charge also escalated to the clinical duty manager for the hospital whenever attendances were starting to rise. Staff told us that this escalation plan was effective in ensuring the overall safety of inpatients in the ED when it became busy.
- In March 2017, the trust's 'Urgent Care Escalation Meeting' minutes reported that the ED was now the 11th best performing trust in the East Midlands region for the proportion of patient handovers on 15 minutes or less. Senior staff of the ED and the trust's executive team attended these meetings. The average time to clinical handover was 21 minutes. This was an improvement from the last inspection.
- The ED was now capturing the initial time to clinical assessment formally for ambulance arrivals. However due to the limitations of the IT system used, it currently did not enable the clinician to always put the 'real time' on electronic records for the exact time when the clinical handover took place. This was something the trust had actioned and had ordered an upgrade on the IT system. Until this IT upgrade was completed in the autumn, staff completing the clinical handover had to ensure they documented this time manually in the patient records. There was a steering group formed looking at the current layout of the patients' ED records to adapt them to make them easier to use.
- The ambulance streaming operation procedure policy had been discussed and agreed with the local NHS ambulance trust.
- During our evening unannounced visit, we saw that patients were kept safe from avoidable harm whilst waiting for clinical handover. Staff in the ED had made significant changes in how they worked to become more efficient and make sure their ambulance patients were handed over and assessed within 15 minutes. This was evident in the gradual improvement of audit results. However, they achieved this initial time to clinical assessment in 64% of patients in May 2017. Work was ongoing to improve this further.

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

- At our October 2016 inspection, we found concerns about the ED's initial rapid triage system that was being used to determine the priority of the patient waiting to be seen and identify any conditions that were potentially life or limb threatening. We were not assured all staff that conducted the streaming were competent and equipped to identify a seriously ill or deteriorating patient. The streaming time was recorded in patient's notes as an 'initial clinical assessment' that was normally recorded on the system within one to two minutes from arrival (booking in). This also meant that patients were recorded as having had this done when this had not yet occurred.
- We also found concerns that the intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, RCPCH, 2012' recommends that all children should have an initial clinical assessment (as described above to include pain score) within 15 minutes were not being followed. The standards state that 'all children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child'. Children who presented to the ED were recorded as having their initial clinical assessment at the streaming/triage position; this was not in line with the guidance. We had observed two children waiting in excess of 15 minutes to attend the children's ED to have their observations taken.
- We raised this as an immediate concern with the trust who took urgent actions to address this, which included a new operational policy that clearly defined which patients should be seen within 15 minutes. The trust immediately put in a process to audit the impact of the changes and provided evidence that an ED consultant had completed an audit at the end of October 2016, which showed an immediate positive impact. The trust planned to continue monitoring and auditing the process until it was fully embedded and present the results to the hospital's quality governance group. The

trust provided us with an update in November 2016 that the standard operating procedure for the 'Streaming of Patients in the Emergency Department' was introduced on the weekend of 29 and 30 October 2016 and was being monitored by spot checks of compliance to the pathway.

- We found during this inspection that the oversight and effectiveness of the streaming system of self-presenting patients had significantly improved.
- The nurse in charge checked all paediatric patients that booked in and were receiving a timely clinical assessment. This monitoring was also included in the two hourly safety rounds. Where, the nurse in charge would check progress and discuss any possible concerns with the triage nurse.
- ED staff had had training on a nationally recognised triage system. The triage and patient observations process carried out in ED met the recommendations of the 'Initial Assessment of Emergency Department Patients (February 2017)' from RCEM.
- Out of 63 nursing staff, 28 had completed the training and 17 were booked onto the course from June 2017 to August 2017. Therefore, at the end of August 2017, 71% of the nursing staff would be compliant with this training. To be an ED triage nurse, staff need to have been in the department for over one year, so therefore 13 members of the nursing team did not require the training, three were on maternity leave/long term sick and two were waiting to be booked onto the course. Therefore, the 'real' percentage of nurses who were able to triage effectively at the end of August 2017 would be 96%. At the time of our unannounced inspection in the evening, all triage nurses we spoke with had completed the triage system training. From a review of staff rotas, there was a triage trained nurse on each shift in the past month.
- The ED had two health care assistants who were in two designated triage rooms. These rooms had observation machines that record the patients' blood pressure, heart rate, and oxygen saturations. There were also thermometers and electrocardiogram (ECG), which is electronic reading of the heart function, machines. Once the patient had booked in with the receptionist, they would then see the triage nurse, who was triage trained. Staff would then record on the IT system that the patient needed observations and any other tests, such as, an ECG, urine sample, blood test or an intravenous cannula. This was then sent electronically to the health care assistant's (HCAs) computer in the triage room. The HCA would then call the patient straight through into the room and complete the observations and any other initial tests. They then recorded on the computer to say that this had been completed and this record captured the initial time to clinical assessment. This provided improved accuracy of capturing the correct times that clinical assessments were being done.
- All ECGs were checked by a doctor who also saw any patients who had clinical observations scoring four and above on the National Early Warning Score (NEWS) record chart. NEWS is a nationally recognised early warning assessment system designed to help staff recognise when a patient may be deteriorating. We saw this process of escalation was working effectively during our inspection.
- During our time observing the triage process of the self-presenting patients, all patients were seen within the 15 minute to initial clinical assessment time.

Nursing staffing

Safety and security of paediatric emergency department

- In our October 2016 inspection, we found that the staffing establishment for paediatric competent nurses in ED was not sufficient to ensure that there was at least one registered nurse (children's branch) on duty 24 hours a day. The lead nurse had developed a paediatric competency framework in February 2016 to train adult trained nurses in essential paediatric competencies. However, staff told us that this was not monitored or signed off to show that staff were competent. We also observed that young patients in paediatric ED were left unattended at times. We highlighted our urgent concerns regarding the staffing levels in children's ED to the trust and immediately after our inspection we received an updated ED policy and revised rota plans to ensure that appropriately trained staff with sufficient cover, were in the children's ED at all times.
- We found during this inspection that the ED had made significant improvements to address the concerns we had found on the last inspection.
- The paediatric ED was only accessible with a trust staff identity (ID) swipe card, so the staff in the unit could monitor who was leaving and entering. We found the paediatric ED was secure and staffed at all times during our inspection.

Urgent and emergency services

- The ED had a staffing increase so senior managers were now able to recruit more registered nurses (children branch) as the staffing establishment had been increased. This was an extra four whole time equivalent nursing staff posts. A registered nurse (children's branch) is a registered nurse who has specific training and competencies to be able to assess and care for children. The trust also appointed a matron for children's ED in November 2016.
- The paediatric ED was now staffed with two registered nurses, one of which was a paediatric-trained nurse. This was significant improvement from the one registered nurse and one health care assistant in place on the staffing rota at the last inspection
- On all shifts during our inspection, there were two registered nurses in the paediatric department and one was always a registered paediatric nurse (child branch). However, staff told us that it was not always possible to staff with at least one registered nurse (child branch) 24 hours a day, seven days a week. If this occurred, one of the registered adult nurses needed to have completed paediatric immediate life support (PILS) and paediatric competencies from the ED's paediatric competency framework.
- We found this to be the case during our unannounced evening inspection. We also looked at the paediatric ED staffing rota records for the month prior to our inspection and we saw from 15 May 2017 to the 11 June 2017, that eight out of 56 shifts were not covered by a registered nurse (child branch). There was evidence on these shifts that the registered nurses that were on duty in the paediatric ED received PILS training which was in line with the Royal College of Paediatrics and Child Health 'Standards for Children and Young People in Emergency Care Settings' (2012) guidance.
- The paediatric ED was included in the nurse in charge's two hourly safety rounds. This ensured that the two registered nurses were present at all times. We saw this safety check taking place throughout our inspection.
- If there was a paediatric emergency in the resuscitation room, then a registered nurse (child branch) would attend from the hospital's paediatric ward. If a nurse was required to leave the paediatric ED, then they would swap with the nurse in the resuscitation area, to always ensure there were two registered nurses in the paediatric area.

Medical staffing

- We did not inspect this element.

Major incident awareness and training

- We did not inspect this element.

Are urgent and emergency services effective?
(for example, treatment is effective)

As we only inspected parts of this key question, we have not rated it.

We found areas where significant improvements had been made:

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

Evidence-based care and treatment

- We did not inspect this element.

Pain relief

- We did not inspect this element.

Nutrition and hydration

- We did not inspect this element.

Patient outcomes

- We did not inspect this element.

Competent staff

- At the last inspection, there was a paediatric competency framework for adult nurses working in the children's emergency department (ED) in line with guidance from the Royal College of Nursing. However, the paediatric competency framework for adult nurses was not being checked or monitored for adult trained staff working in the in the children's ED. We found that not all nurses who should have the required paediatric competency training had received this. This was 23 members of nursing staff out of 71 staff.

Urgent and emergency services

- At this inspection, we found that 13 adult trained nurses had completed the paediatric competencies. According to the training plan in place, the remaining 10 staff were in the process of completing them and would have by the end of June 2017.
- We saw the ED training action plan, which had been developed by the ED practice development nurse. This nurse was responsible for training the nurses in ED in the paediatric competencies. This was a new post for the ED and significant improvements in this area had been made since the last inspection. The ED practice development nurse was checking and monitoring the paediatric competency framework and staffs' compliance with this.

Multidisciplinary working

- We did not inspect this element.

Seven-day services

- We did not inspect this element.

Access to information

- We did not inspect this element.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not inspect this element.

Are urgent and emergency services caring?

As we only inspected parts of this key question, we have not rated it.

We found that:

- Staff showed care and compassion towards patients and their families.
- Patients told us they had been treated with kindness, dignity, and respect.
- Patients' Privacy and dignity was respected at all times.

Compassionate care

- We spoke with 10 patients who were very happy with the care they received in the department. Patients who had visited the department in previous months told us they were seen much quicker this time than previously.
- Staff showed compassion during all times of clinical assessment and treatment. Patients told us they had been treated with kindness, dignity, and respect.
- We observed staff introducing themselves to patients and relatives. Staff would ask the patient how they would like to be addressed. All interactions were observed to be caring and respectful.
- Privacy and dignity was maintained during all interactions and assessment with patients in all clinical areas. Staff we observed showed an awareness of respecting their patient's privacy and dignity by closing curtains around all bays.
- We found that some patients' privacy could not always be maintained when patients were booking into the ED at reception. This was due to the receptionist having to book in a patient next to where the triage nurse would be speaking with another patient. This was especially noticeable when the department was busy, as members of staff, relatives and other patients had to walk past the booking in area to exit the department. Staff had taken all appropriate actions to mitigate this risk by having a partition on the reception desk: however, there was a potential risk that patients were still able to hear each other's personal conversations.

Understanding and involvement of patients and those close to them

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

Emotional support

- We did not inspect this element.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

As we only inspected parts of this key question, we have not rated it.

We found that:

- The hospital failed to meet the national standard for 95% of patients admitted, transferred, or discharged within four hours of arrival to the ED from April 2016 to March 2017 and was below the England average for all of the 12 months.
- Overall, for that period, the emergency department achieved 83% against an England average of 89%, but the trend over time was showing improvements in meeting this performance measure.

Service planning and delivery to meet the needs of local people

- We did not inspect this element.

Meeting people's individual needs

- We did not inspect this element.

Access and flow

- The Department of Health's standard for emergency departments (ED) states 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. The hospital failed to meet this target from April 2016 to March 2017 and was below the England average for all of the 12 months. Overall, for that period, the ED achieved 83% against an England average of 89%, and the trend over time was showing improvements in meeting this performance measure. In March 2017, there had been 7,652 attendances to the ED (an average of 246 each day).
- Performance against the four-hour indicator was a part of the urgent care overall improvement plan and was discussed at board level. It was recognised that performance against this target was affected by other factors in the trust and the wider care network, such as delayed transfers of care and patients that were medically fit for discharge in inpatient areas whilst they waited for appropriate care to be arranged in the community.
- The ED had a recovery plan to improve performance to this target, which had been agreed with local commissioners and other stakeholders. From April 2016 to December 2016, the ED met and exceeded their planned trajectory for improvement in four-hour performance. Senior staff told us that there were a number of contributing factors to meet the national performance measure of 95%, which included an increase in attendances and other trust wide issues such as poor patient flow in inpatient wards.
- During our inspection, the average time to initial clinical assessment for patients was better than 15 minutes (which is the national standard). For the period April 2016 to March 2017, the average time to initial clinical assessment for all patients reported nationally by the trust was 13 minutes. This met the national standard, but was worse than the England average of seven minutes for this period.
- For the period April 2016 to March 2017, the average time from arrival to treatment reported by the trust was 59 minutes. This met the national standard of 60 minutes. This was also in line with the England average of 60 minutes for this period.
- From April 2016 to March 2017, the monthly percentage of patients admitted as an emergency waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average at 24% whilst the England average was 13% for this period.
- In March 2017, the number of patients waiting between four and 12 hours to be admitted to an inpatient bed was 770 (an average of 64 per day). Admission rates from ED to inpatient wards had shown an increase from 25% in the year 2015 to 2016 to 32% in the last year (2016 to 2017). Staff said this reflected more people attending the ED needed admission to inpatient beds due to their condition and acuity.
- From April 2016 to March 2017, the median total time spent in the ED was 158 minutes, slightly longer than the England average of 148 minutes for this period.
- When a decision was made to admit a patient to a hospital ward, no patients waited more than 12 hours in the ED for a bed between January 2017 and March 2017.
- The percentage of patients leaving before being seen in the ED for April 2016 to March 2017 was 1.6%, significantly below the England average of 3.1%.

Learning from complaints and concerns

- We did not inspect this element.

Urgent and emergency services

Are urgent and emergency services well-led?

As we only inspected parts of this key question, we have not rated it.

We found areas where significant improvements had been made:

- The leaders of the emergency department (ED) had made significant progress to improve and address all concerns that we had raised at the last inspection.
- Effective risk management processes were now in place, embedded and monitored.
- Staff at all levels were aware of the concern raised at the last inspection and were involved driving improvement in ED to address these concerns.
- Staff felt that communication from the trust wide team down the leads of ED had improved.
- 'Black breaches' were now reported formally at the trust board so performance was monitored and used to drive improvements. All staff could explain what a 'black breach' was.

Leadership of service

- The leadership in the emergency department (ED) had remained unchanged since the last inspection in October 2016. It was led by an associate general manager, a lead nurse, and a clinical lead consultant. The ED was still part of the urgent care division. The head of nursing for urgent care and the deputy chief operating officer supported them.
- We saw the deputy chief operating officer visible in the department. They were discussing the flow through the department with the nurse in charge and the plans for patients who were waiting to be admitted. This discussion took place at 9.30pm to maintain a safe and organised department for the night ahead.
- We saw clear evidence that the leaders of this service had worked closely with their team to develop and improve the service and encouraged staff at all levels to contribute. They ensured that the staff were aware of the changes implemented and their roles to drive improvements.
- The lead nurse alongside the associate general manager and the clinical lead consultant were continuing to work together to sustain the improvements that were needed to be made to address the concerns raised at the last inspection. They had a clear action plan to follow which defined each action clearly. The ED leaders, and staff team, had made significant improvements to address the concerns we had raised. At the same time, they realised that they were still on a journey of improvement and had plans in place to further improve the service.
- Staff said that at the times when the ED experienced a high patient volume due to no onward flow to inpatient wards, the leaders of the department were visible and worked as part of the team to maintain patient safety.

Vision and strategy for this service

- The urgent care division's vision and strategy had remained unchanged since the last inspection in October 2016. This was to deliver key objectives which included an integrated service, which involved external health and social care partners.
- Staff were aware of the trust wide values that underpinned the divisional vision. There were 'Compassionate, Accountable, Respectful, and Engaging': the 'CARE' values.

Governance, risk management and quality measurement

- The clinical business unit (CBU) risk register for ED that was in place at the time of the last inspection did not accurately reflect the risks in the service that we found during the inspection. The service was not aware of the level of risk regarding patient safety issues until we raised them as an urgent concern. The trust was not aware of the level of risk regarding the 'black breaches' and the governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.
- At this inspection, we found that staff were now aware and continuing to risk assess the mental health assessment room. Staff we spoke with knew it was on the risk register and the importance of why it remains on the register. We saw from the ED action plans what actions had been taken, where further action was needed and how these actions would be sustained and monitored. For example, the mental health assessment triage tool had been implemented and was being used, which included the patient risk assessment. The mental health assessment room, the risk assessment and triage tools were audited as well as this area being included in

the two hourly safety rounds daily. The mental health assessment room was externally validated by the local clinical quality commissioners and local mental health NHS trust who confirmed it to be compliant with national guidance.

- Results from audits of the completion of the risk assessments for patients, showed compliance of 85% in May 2017; this was a marked improvement from March 2017, which showed 66% compliance in the required documentation. The completion of these risk assessments was discussed at the risk management steering group meetings and improvement actions were minuted. We saw evidence of this in the minutes from the March 2017 papers.

- The trust was now aware of the level of risk regarding the 'black breaches' and the governance systems in place were sufficient to allow full oversight at board level of the potential risk to patients. Since the last inspection, the leaders in ED and executive team had put systems in place to monitor and formally report to the trust board on 'black breaches'. There was now oversight at board level of the potential risk to patients and there was a clear escalation plan that was detailed clearly in the ambulance streaming operating procedure.
- There were clinical site meetings led by the chief operating officer, which were held throughout the day and were increased if the ED was facing demand and capacity pressures. The waiting times of ambulances was discussed at these meetings. We attended two of these meetings during our inspection and although there had been no 'black breaches' due to effective patient flow through the hospital, discussions took place with the lead nurse and members of the executive team to discuss reallocation of resources within the ED to facilitate patient flow and safety if this was needed.
- The ED leadership team, along with the chief operating officer (COO) and the deputy COO, had worked closely with the leadership team from the local NHS ambulance trust.

- ED leaders had also made significant improvements to the ED patient triage process to ensure patients received a full clinical handover from ambulance crews within 15 minutes. This was achieved by formal training in the triage system and reallocating health care assistants to perform the clinical observations in a timely manner.
- The initial time to clinical triage process was being monitored and included in the two hourly safety round, where escalation of any unwell patients occurred or if there was a surge in patients attending, then senior staff would reallocate staff in ED to help maintain the flow in triage.

- All staff in ED were now aware of the potential patients safety risks due to a lack of staff compliance with level three training safeguarding of children. The trust's safeguarding policy now reflected national guidance
- Staff had been sent on the appropriate level three training and the department now showed compliance to trust standards of 90%. This was for both nursing and medical staff. There were plans to maintain staff compliance, with training booked for staff on an ongoing rolling process. Staff that had not yet received training were booked onto the course. This was being reviewed and discussed at the safeguarding steering group and workforce development committee.

- We were assured that the ED monitored and risk assessed the paediatric emergency department for its staffing levels and competence as a matter of routine and this practice was now embedded in the ED. It was now staffed with two registered nurses across all shifts. One of these would be a registered nurse (child branch). If they were unable to staff with one registered nurse (child branch) this would be reported formally on their incident reporting system. A risk assessment with mitigating actions was produced for every shift that did not have a registered nurse (child branch): these shifts would be covered by a registered nurse (adult branch) who had the paediatric immediate life support (PILS) training.
- Since the recruitment of the practice development nurse, the increase of staff receiving their paediatric competency training was evident. All required staff to receive this training would be compliant by the end of June 2017.

- Each concern that we had raised on the last inspection had been included onto the urgent care risk register, with escalation to the corporate risk register if the risk scoring was assessed as high.
- All staff we spoke with were aware of the urgent care risk register and could tell us what areas of concern were on

it. The entries on the register had been reviewed regularly and we saw evidence of how ongoing actions were being monitored and recorded to mitigate remaining risk.

Culture within the service

- Staff said how the culture had significantly improved in the team since the last inspection in October 2016. Staff previously felt that not enough support was given to the ED during times of extreme pressure to maintain access and flow. Staff had felt that it was 'an ED problem', with no real support seen to be given from the trust wide team.
- Staff now felt that managers and leaders were visible and approachable. The communication between the leads of ED and the executive team had significantly improved.
- Staff said that now there was effective communication processes in place to convey important information, such as bed availability and escalation of patient risks in times of high demand and capacity pressures in the ED.
- Staff said that their ideas were listened to and they were kept involved with the ongoing changes to improve patient safety within the ED.

Public engagement

- We did not inspect this element.

Staff engagement

- We did not inspect this element.

Innovation, improvement and sustainability

- We did not inspect this element.

Services for children and young people

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The children's and young people's service at Kettering General Hospital consisted of a Neonatal Intensive Care Unit (NICU) and a paediatric ward (Skylark ward) as well as an outpatient centre.

The NICU had 18 cots. There were four cots for babies who required intensive care, six cots for babies who required higher dependency care, and eight cots for babies who required special care.

The paediatric ward had 26 inpatient beds; all 26 beds were open from Tuesday to Friday evenings, when the elective (non-emergency) lists were running. From Friday evenings until Tuesday mornings, only 18 beds were open. There were two beds for children who required closer observation and cubicles, which could be used for isolation. There were 16 beds in cubicles as well as two four bedded bays.

The paediatric assessment unit (PAU) was co-located on the ward and consisted of six beds in total and was open Monday to Friday from 9am to 9.30pm. There were two single cubicles and one four bedded bay.

Services for children and young people had a dedicated outpatients' area for patients attending some appointments. Some patients were seen in adult areas, for example at the dedicated diabetes centre, ear, nose, and throat (ENT) and maxillofacial clinics.

We undertook a focused inspection on 14, 15 and 22 June 2017 to follow up on the issues we identified in Section 29a Warning Notice, which was issued on 18 November 2016. We visited Skylark ward. We spoke with 38 members of staff including nurses, doctors, support assistants other health care professional as well as two patients and their relatives. We observed interactions between staff, patients, and parents. We reviewed four patient records, three policies four risk assessments and four procedures as well as other documents as necessary. We reviewed data provided by the hospital. As this was a focused inspection, we did not give the service an overall rating.

Services for children and young people

Summary of findings

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

We found areas where significant improvements had been made:

- The clinical leadership provided by the paediatric lead nurse had been instrumental in the provision and maintenance of a safe and secure environment for children on Skylark ward.
- There was a clear focus on patient safety, effective risk assessment, and management throughout the service which were owned by all staff.
- Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions.
- Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.
- Risk assessments for children and young people with mental health issues had significantly improved as had staff access and uptake of mental health and conflict resolution training.
- Staff were able to demonstrate their competence in caring for children and young people with mental health issues and care was planned and delivered in line with evidence-based guidance.
- Procedures and guidance available to staff was comprehensive and up-to-date and staff were able to respond appropriately to internal security arrangements that kept children and young people safe.
- There was an effective system for identifying, capturing, and managing risks and issues at team and directorate level. The service risk register reflected the risks associated with children and adolescents mental health service (CAMHS) patients and children experiencing self-harm behaviour and this was reviewed and updated as required.
- Nursing audits were monitoring care provided against expected standards.
- There were positive relationships with CAMHS who were open and responsive to the needs of children with mental health needs on Skylark ward.
- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital. Parents were aware of the children and young people with mental health issues and told us they felt their child was 'safe' on Skylark ward.

However, we found that:

- There were 'blind spots' in the CCTV coverage on Skylark ward. The trust took immediate action to address this once we had raised it as a concern.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff allowing other people to follow them into and out of the ward unchallenged. The trust took immediate action to address this once we had raised it as a concern.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were inappropriately placed on Skylark ward, as sometimes there were no other appropriate placements available in the community. This posed a pressure to staff and patients on the ward. This was reflective of system-wide pressures across the health economy.

Services for children and young people

Are services for children and young people safe?

As we only inspected parts of this key question, we have not rated it.

We found areas where significant improvements had been made:

- Staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions.
- The installation of CCTV and staff swipe card access to the entrance on Skylark ward enabled the entrance/exit to be monitored 24 hours a day seven days a week.
- Policies, protocols and 'lockdown' arrangements enabled staff to respond immediately if a child was found to be missing. Lockdown is the immediate closure of the ward exits for security purposes.
- Risk assessments for children and young people with mental health issues had significantly improved and were becoming embedded in practice. Processes and audits were in place to monitor this and ensure practice had become embedded in the service.
- Nurses and assistant practitioners had completed competency based risk assessment training, mental health, and conflict resolution training.
- All security staff had completed training in the appropriate and safe restraint of children and young people.
- Staff on Skylark ward were "owning" security issues and had developed effective working relationships with the security team.

However, we also found that:

- There were 'blind spots' in the CCTV coverage on Skylark ward. The trust took immediate action to address this once we had raised it as a concern.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff allowing other people to follow them into and out of the ward unchallenged. The trust took immediate action to address this once we had raised it as a concern.
- Children and young people with mental health issues who exhibited violent and aggressive behaviours were sometimes inappropriately placed on Skylark ward, as there were no other appropriate placements available in the community. This posed a pressure to staff and for care of patients on the ward. This was reflective of system-wide pressures across the health economy.

Incidents

- We did not inspect this element.

Cleanliness, infection control and hygiene

- We did not inspect this element.

Environment and equipment

- At our October 2016 inspection, we found that some environmental aspects of the paediatric ward (Skylark) were unsafe and not monitored or managed: we raised this with the trust urgently who took immediate actions. There were ligature risks within the department, for example, shower rails, that had not been risk assessed appropriately. We raised this as an urgent concern with the trust, which provided us with assurance promptly to mitigate the risks. Action taken included introducing a new risk assessment to ensure the level of care required by patients was assessed on admission; this was developed in conjunction with the Child and Adolescent Mental Health Service (CAMHS). The service had also spoken with CAMHS regarding training and competency assessments which were being developed and we were told the lead matron would review all CAMHS assessments daily.
- We also found that Skylark ward was not adequately secure to ensure unauthorised people did not enter the ward. This meant that someone could access the ward without being challenged. There were no arrangements in place to minimise the risk of a baby or child abduction or children/young people absconding from the department. We raised our concerns regarding the entrance and exit of the ward with the trust who took prompt action. Action taken included installing a buzzer entry and exit system as well as CCTV. A security guard was also placed outside the ward 24 hours per day, seven days per week until staff only card swipe access was installed. The trust also revised policies and procedures regarding the potential of a child going missing and enhanced staff training in this area.
- Skylark ward was on level two of the main hospital site. Outside the ward was a balcony, which overlooked the ground floor. This presented a risk to patients admitted to the ward with mental health concerns who may

abscond from Skylark ward. We raised concerns about the potential risks the balcony presented, and the trust carried out risk assessments urgently. The service took immediate action to ensure the doorway was manned by a security guard 24 hours a day, seven days a week until the area could be 'made safe'. Following extensive risk assessment and coupled with the improved security at the ward entrance at the start of November 2016, longer term plans were drawn up to ensure this risk was addressed for all patients admitted to the ward.

- The hospital did not have an abduction policy and there were no clear guidelines on what action to take. The staff we spoke with on Skylark ward were unsure how they would respond to an abduction or attempted abduction and each member of staff we spoke with told us varying ways they would manage or respond to this scenario. There was no policy or agreed protocol should a young person abscond from the unit and staff were unclear of action to be taken other than to report this to the police. There was no protocol for 'lockdown' arrangements and risks of potential threats or hazards which may prompt a lockdown had not been considered. Lockdown is the immediate closure of the ward exits for security purposes. We raised this with the trust which took immediate action and revised the flowchart for the missing/abducted child and we were told this had been displayed in all areas with communication of this undertaken at each handover.
- During this inspection, we reviewed information as to how the safety of all patients being cared for on Skylark ward was being ensured until the environmental concerns regarding the exit door system and the adjacent balcony had been addressed. Comprehensive risk assessments and associated risk management plans were in place for all CAMHS patients and children at risk of self-harm behaviour. All risk assessments contained an environmental risk assessment and there was clear evidence of robust plans of care including the appropriate level of observation and supervision required for children and young people. Nurses and assistant practitioners had undertaken training on how to complete the self-harm risk assessment tool and a competency based assessment package. This demonstrated staff on Skylark ward were assessing, monitoring, and managing the risks to prevent or minimise harm to children and young people with mental health conditions.
- The exit to Skylark ward was a concern at the last inspection, as there had been no safe method of checking all people leaving the ward. This represented a risk to children and young people of going missing. A security camera and swipe card system were installed on Skylark ward in November 2016. Staff controlled the system using an intercom door release button. Entry to the ward was managed by staff using an intercom at the nurse's station and was supported by security cameras to enable person's not carrying a swipe card to enter the ward. The system reduced the risk of any child or young person absconding from the ward.
- Whilst the staff on Skylark ward were very aware of security issues, we observed visiting staff throughout the inspection allowing other people to follow them into and out of the ward unchallenged. We also observed visitors were able to enter the ward by tailgating through the double doors, once the original requesting visitor had entered the department. The doors remained open for a period of 10-15 seconds. This had been risk assessed in October 2016 and the original time of 20 seconds reduced to fifteen seconds. The lead nurse told us this enabled children in their beds or with equipment to enter and exit the ward safely. We reviewed the risk assessment undertaken in October 2016 and noted it was reviewed in December 2016 and the risk score had been downgraded. The risk was reviewed again and the risk scores maintained in April 2017 and May 2017. The risk was identified as a corporate risk and had been entered onto the trust risk register and clinical business unit risk register (CBU) in October 2016.
- We noted during our focused inspection there were "blind spots" in the CCTV coverage on the Skylark ward main corridor, which led to the ward. This could enable people to enter the ward unseen. We raised our concerns with the trust regarding entry to the ward at the time of the inspection. During our inspection, the trust placed additional information on the outside of the double doors advising staff and visitors of the safeguarding risks posed to children and young people around tailgating and unauthorised entry to the ward. We advised the security manager during the focused inspection of the "blind spots" in the main corridor and he took action to address them. The security manager was involved in briefing trust staff through staff induction and mandatory training to support the ongoing development of a safety culture across the trust.

- The lead nurse advised us that the long-term plans regarding environmental changes to the balcony outside the exit to the ward were no longer required. This followed the enhanced assessment and management of CAMHS patients and children at risk of self-harm behaviour. This was supported through increased monitoring of the ward exit and installation of CCTV and swipe cards. Assessments undertaken in October 2016 by the trusts health and safety and estates departments were recorded on the clinical business unit (CBU) risk register in October 2016. The Health and Safety Executive reported in January 2017 they were confident that the balcony complied with building regulations and did not need to be reassessed. A review of the initial risk assessment was undertaken in December 2016 and the risk score was reduced following the implementation of the controls that were put in place. The risk assessment was reviewed and the risk scores were maintained in April 2017 and May 2017.
- Nurses, assistant practitioners, play specialists, and administrative staff were clear about the policies and protocols to follow when a child was found to be missing. Staff were able to explain a clear "lockdown" procedure to be operated immediately in all cases when a child was found to be missing. The flowchart displayed at the nurses' station was specific to the ward environment and was reflective of the needs of the patients being cared for on the ward. Staff had experience of the 'lockdown' protocol as a child had absconded twice from the ward in the last four weeks. Staff were confident in the effectiveness of the protocol and reported the child had been safely returned to the ward each time they had absconded. Staff had participated in two practice 'live' drills and the learning had helped to inform the protocol which was revised to incorporate trust wide emergency communication systems. This had facilitated absconding children or young people to be located and returned to the ward earlier.
- During our inspection, we observed staff managing a challenging situation regarding a patient very effectively. Staff managed this situation in line with the "lockdown" arrangements We observed a staff member had sustained a minor injury and the incident reporting process was followed correctly and was in line with trust policy. We saw that security staff were placed outside the fire exit until additional alarms were fitted to the fire exits which were planned to be completed the following day.
- All staff told us they were now more confident in managing physical aggression from patients, as they had attended mental health and conflict awareness training. However, staff expressed concerns around the increasing number of CAMHS patients or children presenting with deliberate self-harm behaviours on Skylark ward. Security staff were provided to the trust through a third party and were accountable to the security manager. Approximately 25 security staff were deployed in the trust and all had undertaken training in the restraint of children and young people in October 2016. Security was available 24 hours a day seven days a week if it was required and we observed two security staff on the ward to support nurses 24 hours a day seven days a week when required.
- All children and young people admitted to Skylark ward following a self-harm episode were managed using the countywide self-harm pathway. The pathway incorporated the self-harm risk assessment tool to identify if they were low, medium or high risk of further self-harm behaviour. Children and young people assessed as being a medium risk were kept in sight of the nurse / assistant practitioner who recorded observations hourly. Children and young people assessed as being high risk required 1:1 supervision and were kept within arm's length at all times and observations were recorded hourly or more frequently and were dependent on clinical need. An additional staff member was required for the 1:1 supervision of a vulnerable child.
- All staff on Skylark ward had completed competency training on using the self-harm risk assessment tool and was able to assess the appropriate level of supervision required by the child or young person. The level of supervision was clearly documented on the four self-harm risk assessments we reviewed. Staff from within the Clinical Business Unit had their competence assessed and recorded on the self-harm risk assessment tool and were given a comprehensive handover. The lead paediatric nurse told us consideration for the safety needs of other patients and staff on the ward would be dependent on individual circumstances. When required security staff would be deployed to observe the exit to Skylark ward on a 24-hour basis. This would be reviewed

in light of the patient's clinical condition. Security staff were observing the ward and fire exit and were providing additional 1:1 supervision to care staff throughout our focused inspection.

- On the first day of this inspection, we noted that the floor above Skylark ward contained a lift landing area, which contained a number of musical instruments and Christmas decorations that were not stored away. The door to the lift plant room had no lock and ligature risks were evident in this unsupervised area. We raised this as a concern to the trust, as there was a potential risk that a young person may go onto this area if they were to abscond from Skylark Ward. The trust took immediate actions to address this concern and made the area safe. We returned on the last day of our inspection, and found this area was safe and presented no risks to patient safety.

Medicines

- We did not inspect this element.

Records

- We did not inspect this element.

Safeguarding

- We did not inspect this element.

Mandatory training

- We did not inspect this element.

Assessing and responding to patient risk

- At our October 2016 inspection, we found that risks to patient safety were not always appropriately managed. Arrangements for patients admitted with mental health needs were not suitable, dependency tools were not used, and there were no criteria for which patients should be admitted to the high dependency unit (HDU) or a policy for their care and treatment. The risk assessments for patients who had mental health needs were not always consistently completed and lacked detail. We raised our concerns with the service about the suitability of the risk assessment for patients with mental health needs. The hospital promptly revised their risk assessment with advice from a mental health nurse.
- Patients who were admitted to the ward with mental health concerns, for example, if the patient had self-harmed or attempted suicide, were not routinely provided with one to one care in accordance with hospital policy. During the inspection, we identified that there was no formal risk assessment to determine whether one to one care was required, if the environment was suitable and whether adjustments were needed. When one to one care was required, it was provided by ward staff who had not received mental health training, or by the child's parent or carer. If the parent or carer provided one to one support, nursing staff provided care and treatment for any medical health needs. We raised our concerns with the trust at the time who took immediate action. A new risk assessment tool was devised. The risk assessment was developed with the assistance of a mental health nurse and included an assessment of their environment as well as requirement for specialist one to one care. The hospital reported that further staff training, risks assessments, and actions were being developed in relation to the safety of the environment as well as providing nursing staff with some basic mental health training.
- During this inspection, we reviewed the monthly self-harm audit of children and young people admitted to Skylark ward. There were 138 CAMHS patients and children at risk of self-harming behaviours admitted to Skylark ward from January 2017 to May 2017. The paediatric lead nurse said there were good open relationships with CAMHS team in the local NHS mental health trust who were always responsive to the needs of patients with mental health issues. Waiting times for assessments were usually on the day of referral to the ward. However, if admission occurred after midday the assessment was likely to be delayed until the next day. We observed a case conference regarding the young person who had absconded during our focused inspection. The lead paediatric nurse on Skylark ward had initiated the meeting.
- In May 2017, there was a significant increase in the number of admissions to the ward of young people with mental health assessment needs (44) which was double the usual rate of around 23 a month. Children and young people with deliberate self-harm behaviours were risk assessed which identified 46% (20) were high risk and required 1:1 supervision. 10% (4) were medium risk and had "within eyesight observation" and 44% (19) were low risk and therefore had general observation.
- Due to the high volume of patients with self-harming behaviours on the ward throughout this concentrated period, the paediatric lead nurse told us it was

necessary to supervise in a bay in to order to provide appropriate and safe supervision. On most days in May, three to four new referrals were received and five young people had two or more admissions to Skylark ward in a three-week period. The security team provided support as required and one young person required bed watch supervision in addition to 1:1 supervision from ward staff as they were violent and abusive and had assaulted a member of ward staff.

- Staff told us they were confident following their risk management and mental health awareness training in caring for these patients. However, staff expressed concerns around the appropriateness of Skylark ward to care for children and young people who exhibited violent and aggressive behaviour. The ward was not a secure unit and patients had previously absconded from the ward. Patients assessed by the medical team and deemed as medically fit waited on Skylark ward until an in-patient specialist mental health bed became available. There was limited availability of specialist in-patient mental health beds in Northamptonshire and nationally. This was reflective of system-wide pressures.
- Following the previous inspection in October 2016, a mental health risk assessment tool and competency assessment tool was developed. This was a joint initiative led by the paediatric lead nurse and an advanced mental health practitioner from the CAMHS team. Implementation was through joint training sessions in October 2016 to November 2016 for staff responsible for coordinating shifts and with experience of caring for children and young people presenting with challenging behaviours. Training records showed 93% of staff had attended the knowledge and risk assessment tool sessions and completed their competency assessment packages. Three staff on long-term sickness or maternity leave would complete the training on their return to Skylark ward.
- The paediatric lead nurse reviewed the enhanced risk assessment tool daily and incorporated the findings into a monthly audit. Compliance for the completion of the enhanced risk assessment tool was 100% for the period January 2017 to May 2017. This demonstrated patients were receiving the appropriate level of care and the tool was becoming embedded in practice.
- In the women's and children's health division two practice 'live' drills were undertaken on the maternity unit and Skylark ward in November 2016 and May 2017. Scenarios of an abducted child and missing child tested staff understanding and compliance with the internal security (abduction) policy and flow chart. Learning from the debriefing sessions identified: switchboard to be part of the information cascade to ensure notification of all parties and staff to be encouraged to use the emergency call bell on the ward. This had been incorporated into the abduction flow chart that was displayed at the nurse's station.

Nursing staffing

- We did not inspect this element.

Medical staffing

- We did not inspect this element.

Major incident awareness and training

- We did not inspect this element.

Are services for children and young people effective?

We did not inspect this key question.

Are services for children and young people caring?

As we only inspected parts of this key question, we have not rated it.

We found that:

- All interactions we observed between staff, children and young people, and their carers, were caring, compassionate, respectful, and friendly.
- Parents were aware that some children and young people with mental health issues were being cared for on the ward at times and told us they felt their child was well cared for by the staff and felt 'safe' on Skylark ward.

Compassionate care

- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital. Parents were aware that children and young people with mental health issues were being cared for on the ward at times and told us they felt their child was well cared for by staff and 'safe' on Skylark ward.

Services for children and young people

- All interactions we observed between staff, children and young people, and their carers, were caring, compassionate, respectful, and friendly.
- Nurses, consultants, and support staff were friendly and welcoming to children and their families and were skilled in communicating with children and young people. Children and their relatives told us how happy they were with the care throughout the hospital. They said staff were very caring, one relative said "they always felt fully informed".
- A parent told us "All staff were caring, reassuring and friendly and the care of my child throughout their hospital stay was excellent, I could not fault the care at all".

Understanding and involvement of patients and those close to them

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

Emotional support

- Staff were able to provide appropriate support to children and young people and their families and also signposted them to appropriate services outside the hospital.

Are services for children and young people responsive?

As we only inspected parts of this key question, we have not rated it.

We found that:

- Arrangements with the children and adolescents mental health service (CAMHS) provided by the local community NHS trust were responsive to the needs of children and young people with mental health issues.

However, we also found that:

- Children and young people with mental health issues who exhibited violent and aggressive behaviours were sometimes inappropriately placed on Skylark ward, as there were no other appropriate placements available in the community. This posed a pressure to staff and for care of patients on the ward. This was reflective of system-wide pressures across the health economy.
- Delayed discharges on Skylark ward were reflective of system wide pressures in the local health economy.

Service planning and delivery to meet the needs of local people

- We did not inspect this element.

Access and flow

- During our inspection, we identified that in May 2017, there were 44 admissions of children and young people with deliberate self-harm behaviour. This was double the usual admission rate of around 23 a month. This was the highest number of admissions experienced by Skylark ward for this care group. System-wide children and adolescents mental health service (CAMHS) pressures were increasing throughout Northamptonshire. As in previous months, there was a good response from the local CAMHS team but, despite additional support, there were three occasions where CAMHS were unable to undertake any assessments on Skylark ward. This resulted in delayed discharges from Skylark ward. This was the first time in many months that CAMHS had been unable to undertake at least one assessment a day on Skylark ward.
- In the period January 2017 to May 2017, there were nine children and young people waiting for in-patient specialist mental health beds. The average waiting time was between one and six days with the average being two days. In the same period, three children and young people waited on the ward for up to seven days due to a lack of specialist social care placements in Northamptonshire.

Meeting people's individual needs

- We did not inspect this element.

Learning from complaints and concerns

- We did not inspect this element.

Are services for children and young people well-led?

As we only inspected parts of this key question, we have not rated it.

We found areas where significant improvements had been made:

- The clinical leadership provided by the paediatric lead nurse had been instrumental in the provision and maintenance of a safe and secure environment for children on Skylark ward.
- There was a clear focus on patient safety, effective risk assessment, and management throughout the service, which were owned by all staff.
- Governance systems in place had significantly improved so that staff, at all levels, from ward to board, understood the areas of risk within the service, and we saw that a series of actions had been implemented and embedded in the service to minimise risk to patients.
- The clinical business unit (CBU) risk register reflected the risks associated with children and adolescents mental health services (CAMHS) patients and children experiencing self-harm behaviour, and was reviewed and updated as required.

Leadership of service

- Two senior staff had left Skylark ward following the last inspection in October 2016. Recruitment arrangements were in place to appoint to the vacant posts and the paediatric lead nurse was providing the leadership on Skylark ward at the time of our focused inspection.
- We ascertained through observation, staff and patient discussions, safe working practices, enhanced security systems, training and competency assessments, how instrumental the paediatric lead nurse had been in leading and maintaining a safe and secure environment for children on Skylark ward. This was evident as staff were "owning" security and risk management issues and had developed effective working relationships with the security team.

Vision and strategy for this service

- The vision and strategy for the service had not changed in respect of the service vision and business plan for the Women and Children's clinical business unit (CBU). However, the paediatric lead nurse, nurses, assistant practitioners, play specialists, and administrative support told us how Skylark ward were now providing a "safe" environment for the care and support of children and young people and recognised the importance of maintaining this.

Governance, risk management and quality measurement

- During our previous inspection, we found that the risk management processes in place were not sufficient to recognise, assess, monitor, and review and therefore reduce risks.
- The CBU risk register in place at the time of the inspection did not accurately reflect the risks that the failure to monitor, assess and mitigate the risks to patients due to the lack of effective security systems for Skylark ward.. The trust was not aware of the level of risk regarding this concern until we raised this as an urgent concern. The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.
- On this inspection, we found that risk management processes that were now in place had significantly improved and were sufficient to recognise, assess, monitor, review and therefore reduce risks. Governance systems in place had significantly improved so that staff, at all levels, from ward to board, understood the areas of risk within the service, and we saw that a series of actions had been implemented and embedded in the service to minimise risk to patients. Staff were able to demonstrate their competence in caring for children and young people with mental health issues due the training delivered as a result of our last inspection. Security measures now in place were monitored and reviewed on a regular basis by the service. Care was planned and delivered in line with evidence-based practice. Nursing audits were monitoring care provided against agreed standards.
- Our inspection identified that the CBU risk register reflected the level of risk regarding environmental factors and concerns regarding risk assessment and care

provision of CAMHS patients and children experiencing deliberate self-harm behaviours. The risk had been entered onto the risk register in October 2016 and reviewed in December 2016. The risk score was reduced following the controls that were put in place.

- Risks were recorded on the incident reporting system and paper copies printed and added to the risk register folder on Skylark ward. When new risks were identified, a risk assessment was undertaken and approved through the paediatric division senior management team and uploaded onto the risk register. Depending on how high the risk was, it would be escalated to the CBU governance meeting and to trust directors as necessary. This demonstrated that the risk management process that was in place was sufficient to recognise, assess, monitor and review and therefore reduce risks. Risks were frequently reviewed and we saw clear evidence of mitigating actions in place to reduce risks. These actions were owned by responsible staff and reviewed as per trust policy.

Culture within the service

- Staff we spoke with said that morale was now improving after the last inspection report was published and that all staff were committed to ensuring the service delivered the best possible care for all patients. Staff said they were well supported by local and senior managers of the trust.

Public engagement

- We did not inspect this element.

Staff engagement

- We did not inspect this element.

Innovation, improvement and sustainability

- We did not inspect this element.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Kettering General Hospital NHS Trust has outpatients departments at four sites, Kettering General Hospital, Nene Park outpatients' clinic, Corby diagnostic centre (Nuffield centre) and Isebrook outpatients. These last three are satellite services managed by the department based at the hospital and were not included in this inspection. Each year this hospital facilitates over 250,000 outpatient appointments.

The majority of clinics at Kettering General Hospital are provided from a central outpatients department. However, specialities such as obstetrics and gynaecology, trauma and orthopaedics, diabetes, pain management and anticoagulation services are provided from satellite departments on site.

There are consultant and nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients department. Outpatient clinics are held from Monday to Friday from 8am until 6pm.

The diagnostic imaging department is within the clinical support services business unit within the hospital. The department provides a full range of diagnostic imaging types, including general radiography, computerised tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine, and interventional radiology. They perform approximately 20,000 examinations each month.

The unannounced inspection took place on the 14 and 15 June 2017, during which we spoke with six members of staff and looked at 20 medical records. We also spoke with senior managers of the trust on the 22 and 28 June 2017.

Summary of findings

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

We found that:

- Staff were kind and caring in all interactions with patients that we observed.
- The total number of patients waiting over 52 weeks for their treatment on the admitted and non-admitted pathways had improved. This had reduced from 413 to 178 patients waiting.
- Where things had gone wrong, duty of candour was maintained. This was evidenced in the medical notes of patients who had suffered moderate harm as a result of waiting for treatment.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust also had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete Referral to Treatment (RTT) pathways for high risk specialties.
- There was oversight on the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.
- The trust's RTT performance had increased from 69% (based on unvalidated data) in October 2016 to 75% in June 2017.
- The hospital was performing better than the national operational standards for all types of cancer referrals.

Outpatients and diagnostic imaging

- There were a total of 178 patients (for both admitted and non-admitted RTT pathways) waiting over 52 weeks. This was an improvement from the last inspection.
- The trust had returned to national reporting of RTTs from March 2017 following support from NHS Improvement. 'RTT Confirm and Challenge' meetings regarding RTT performance were being held every two weeks. Data from April 2017 to June 2017 showed actions by speciality, current RTT performance, additional resource updates, and learning from harm reviews.
- An elective care e-learning programme to help teams reduce waiting times and improve access was launched by the trust in June 2017 and 93 % of eligible staff had had this training. Additional weekend lists and the use of private providers were used to reduce patient waiting times. Referrals were prioritised by clinical urgency.
- Managers in the service now had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen.
- This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- The trust had recruited its own team of data validators.

However, we also found that:

- The trust was planning to carry out harm reviews on those patients who had died whilst on a waiting list.
- The number of patients waiting for 31 weeks had increased from 9% to 27%. Managers were making plans to address this increase.

Are outpatient and diagnostic imaging services safe?

As we only inspected parts of this key question, we have not rated it.

We found that:

- The total number of patients waiting over 52 weeks for their treatment on the admitted and non-admitted pathways had improved. This had reduced from 413 to 178 patients waiting.
- Where things had gone wrong, duty of candour was maintained. This was evidenced in the medical notes of patients who had suffered moderate harm as a result of waiting for treatment.
- The trust had carried out clinical harm reviews on 1,281 patients waiting over 52 weeks for their treatment. This represented 75% of all patients that had waited over 52 weeks.
- The trust also had a prioritisation system for carrying out harm reviews for those patients waiting more than 46 weeks on incomplete referral to treatment (RTT) pathways for high-risk specialties.
- There was oversight on the potential deterioration of patients waiting over 18 weeks. Staff communicated with patient's GPs to find out about potential harm. Procedures were in place to prioritise patients whilst waiting on RTT pathways.

However, we also found that:

- The trust was planning to carry out harm reviews on those patients who had passed away whilst on a waiting list.

Incidents

- From October 2016 to May 2017, the service reported one never event related to a wrong tooth extraction. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers**.** Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.
- Learning from a never event in the maxillofacial department was evident on discussion with staff and we

saw that new checklist and procedures had been introduced as a result of learning from this never event. Staff were fully aware of the new systems designed to prevent a similar reoccurrence, which included surgeons to check teeth pattern since the patient was listed for surgery.

- In accordance with the Serious Incident Framework 2015, the service reported 13 serious incidents (SI) in outpatients, which met the reporting criteria set by NHS England from November 2016 to May 2017. Three incidents related to delays in treatment meeting the SI criteria. Staff we spoke with demonstrated learning from incidents. Senior managers had investigated these incidents and we saw action plans to prevent re-occurrence were in place and being monitored.
- Staff understood their responsibility to raise concerns, record and report safety incidents, concerns and near misses, and how to report them. When things went wrong, thorough and effective reviews were carried out. Staff were confident in using the trustwide electronic reporting system.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities). The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of the Duty of Candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. Staff knew the threshold for triggering Duty of Candour was when moderate harm had been experienced. This was in line with the trust policy.
- We reviewed the medical notes of two patients who had suffered moderate harm while waiting for their treatment and saw that clinical staff had written to them offering an apology. Where a serious incidents had occurred, we saw written evidence from the trust to the relevant person in correspondence containing information that had been discussed.
- We requested for evidence of harm review process for patients who died whilst on the waiting list. The trust said the clinical harm review (CHR) and governance process was intended to include patients who had died whilst awaiting treatment but they were conducting CHRs on patients who had waiting over 46 weeks before receiving treatment. The trust was not able to provide evidence of CHRs for patients who had passed away whilst waiting and senior managers stated they would be reliant on GPs informing the trust of deaths of patients who were on a waiting list. The trust had not been informed of any such cases.

Cleanliness, infection control and hygiene

- We did not inspect this element.

Environment and equipment

- We did not inspect this element.

Medicines

- We did not inspect this element.

Records

- We did not inspect this element.

Safeguarding

- We did not inspect this element.

Mandatory training

- We did not inspect this element.

Assessing and responding to patient risk

- During our last inspection in October 2016, we found there was a system in place to monitor and manage the risk to patients on the waiting list. We saw that the hospital had ceased reporting the Referral to Treatment Time (RTT) in November 2015 due to the hospital data quality concerns. In October 2016, the service reported a reduction of patients waiting over 52 weeks from 25,000 to 413 and improvements in the incomplete RTT pathway target from 30% to 69%. This was being monitored through an assurance group involving regulators and reported directly to the hospital board. After completing an improvement programme, which had been verified by external organisations, the hospital returned to reporting their waiting list data in March 2017. Figures provided by the trust during this inspection showed that the total number of patients on both the admitted and non-admitted pathways waiting over 52 weeks had dropped from 413 to 178 patients. This was an improvement.

- The trust had implemented a 'Clinical Harm Process and Governance process for patients experiencing delay in treatment on the 18 week RTT pathway' at the start of July 2016, which reflected agreed amendments from the external RTT assurance group meeting held in May 2016, where NHS England, NHS Improvement (NHSI) and the clinical commissioning group were present. Feedback from NHSI's Intensive Support Team had also been reflected in this policy.
- Other NHS organisations with RTT problems had completed the RTT data validation process prior to commencing any clinical harm reviews, however, for a timely response the trust had commenced clinical harm reviews (CHRs) in parallel with the ongoing data validation process. A five-phase approach for CHRs was implemented and this approach was to be revisited depending on the outcomes of the RTT data validation findings. The CHR process was underpinned by risk based prioritisation of specialities:
- Phase1

For non-admitted and admitted pathways, CHRs to be carried out for all patients that had waited over 52 weeks who have had treatment.

- Phase 2

For admitted incomplete pathways, CHRs to be carried out for high risk specialities selected for patients that had waited over 46 weeks (validated data).

- Phase 3

For non-admitted incomplete pathways, CHRs would be carried out for high-risk specialities from 46 weeks onwards, which will be subject to data validation.

- Phase 4

This was a repeat of phases 2 and 3 in the remaining lower risk specialities.

- Phase 5

This would also include review of those patients that had passed away whilst on an RTT waiting list.

- The agreed process was that if any clinical speciality pathway identified an increased frequency of harm or high levels of harm, then the clinical harm review process would be extended to before 46 weeks.
- The CHRs ensured that all patients who had waited for greater than 46 weeks or longer for treatment had their clinical record reviewed to ascertain if harm had occurred. If harm was identified, then a level of harm was assigned (no harm, low, moderate, or severe). Some patients would have already received treatment and some would be scheduled for an appointment and were actively waiting. All RTT patients were also undergoing an administrative validation process to identify all patients that had waited 46 weeks or more. The harm review process and data validation process had been carried out concurrently. Patients' notes and clinical records were reviewed by the relevant clinicians using a standardised form. The clinician determined if harm had occurred and what the level of harm was. However, we found that clinical notes were reviewed with no direct communication with the patient to ascertain if their symptoms had worsened or not.
- This review of the clinical record may have meant that it was not possible to ascertain if clinical harm had occurred or what level of harm had occurred without a further review of the patient. If this was the case, then an urgent outpatient appointment was scheduled or a review of the patient took place when attending for treatment (whichever was sooner). We saw from our review of patient's notes instances where outpatient appointments had been brought forward as a matter of urgency due to the possibility of the patients experiencing harm.
- We looked at 20 records of patients and saw that clinical harm reviews had been carried out on all the patients. The medical director and a clinical harm coordinator oversaw the reviews. Patient medical notes were sent to relevant consultants who were required to ensure that patient reviews were conducted. Patients who were found to have been caused potential harm as a result of any delays in treatment were identified. The outcomes of this process were included in the reports to the external RTT assurance group and the trust's board.
- Information provided by the trust showed that as of 12 July 2017, 1,709 patients had waited over 52 weeks for an appointment (both non-admitted and admitted RTT pathways) and 1,281 patients had had a CHR carried out. Of these, 1,137 had suffered no harm and 133 had suffered low harm. Of the 437 CHRs not yet completed, reasons were due to staff awaiting patient notes in 292 cases and we saw that 113 CHRs were in progress.
- For the completed CHRs, 89% showed no harm had been experienced, 10% showed low harm and 0.2% showed moderate harm.

Outpatients and diagnostic imaging

- A total of two patients had been found to have been caused moderate harm as a result of waiting over 52 weeks for treatment. We looked at the patient files for both these cases and saw that duty of candour processes had been followed and senior doctors had met with the patients. Learning from these incidents had been reviewed as part of the overall trust and stakeholder group assurance meetings regarding RTTs and the CHRs.
- The trust had identified high risk specialties as a result of these CHRs: harms experienced by patients were:
  - Ear, nose and throat (with a total of 60 low harms identified).
  - Trauma and orthopaedics (with a total of 32 low harms identified).
  - General surgery (with 20 low harms identified).
- In accordance with Phase 1 of the trust's agreed CHR process, the high risk specialities had been identified for patients on non-admitted and admitted pathways that had waited over 46 weeks who had had treatment were ophthalmology, urology, and general surgery. CHRs had commenced for patients in these specialities as of March 2016.
- In accordance with Phases 2 and 3 of the trust's agreed CHR process, for patients on non-admitted and admitted incomplete pathways (patients still awaiting treatment), the high risk specialities (with validated RTT data) for patients waiting over 46 weeks were:
  - Trauma and orthopaedics (with a total of nine low harms identified).
  - Ear, nose and throat (with a total of four low harms identified).
  - Ophthalmology (with one low harm identified).
- We saw that in these high-risk specialities, the trust had carried out 140 CHRs, with 12 to be completed (8%). In 14 cases, low harm had been identified (10%).
- We also saw that the trust had carried out 24 CHRs for the lower risk specialties, with 34 to be completed (59%). In two cases, low harm had been identified (8%).
- All low or moderate harm cases identified were reviewed by trust's medical director and any contentious issues were taken to expert panel of senior clinicians for review. We also saw that a sample of no harm cases were reviewed on a weekly basis for quality assurance purposes and that low harm cases from two GP practices were sent to primary care physicians to conduct a clinical review on the patients' primary care record.
- The trust had an 'Elective care access policy', which had been reviewed and ratified by the trust's management committee on 25 April 2017. This policy gave guidance for the prioritisation of patients on the RTT waiting list and which stated that where patients had waited over 35 weeks, they would become a higher priority and treated as soon as possible. Where a patient had waited longer than 35 weeks on the RTT pathway, the policy stated that when booking outpatient appointments, patients who were on a two-week wait pathway would be prioritised, followed by urgent appointments and higher priority cases as agreed by the clinical teams.
- The hospital relied on patients to contact their GP in case of any concerns. The trust had written to all primary care providers to make them aware of the RTT position and requested that if any GP had concerns about a particular patient they should bring it to the attention of the relevant consultant. A range of information had been sent to all local GPs, and the trust had also raised the waiting list issue in the local media and on their public website, to raise public awareness of the delays in receiving treatment for patients on RTT pathways.

Nursing staffing

- We did not inspect this element.

Medical staffing

- We did not inspect this element.

Major incident awareness and training

- We did not inspect this element.

Are outpatient and diagnostic imaging services effective?

We did not inspect this key question.

Are outpatient and diagnostic imaging services caring?

As we only inspected parts of this key question, we have not rated it.

- Staff were kind and caring in all interactions with patients that we observed.

Compassionate care

- Staff were kind and caring in all interactions with patients observed.
- Patients' privacy and dignity was respected by staff in the areas we visited.
- Patients spoke positively of the support they had received from staff.

Understanding and involvement of patients and those close to them

- We did not inspect this element.

Emotional support

- We did not inspect this element.

Are outpatient and diagnostic imaging services responsive?

As we only inspected parts of this key question, we have not rated it.

We found that:

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

However, we also found:

- The number of patients waiting for 31 weeks had increased from 9% to 27%. Managers were making plans to address this increase.

Service planning and delivery to meet the needs of local people

- We did not inspect this element.

Access and flow

- During our last inspection in October 2016, we found that patients were unable to access the majority of outpatient services in a timely way for initial assessments, diagnoses, or treatment. There were long waiting lists with patients waiting up to 52 weeks for outpatient services. At October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed 413 patients had been waiting over 52 weeks; however, their data was not validated so we could not be assured of how many patients were waiting for long periods of time.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter.
- The trust senior managers told us that the hospital was not reporting RTT performance for incomplete pathways at the time of inspection due to historical problems with their data that occurred after an IT system upgrade in August 2015. The issues had compromised the validity of recorded waiting times on their patient tracking list which monitored how long patients waited for their first outpatient appointment. This meant the trust could not be assured that they were monitoring the patient waiting times accurately or that patients were being seen within the 18 week national standard. They had not reported RTT performance nationally since November 2015 but planned to begin again by December 2016.
- When the issues were identified in November 2015, there were eight patients identified as having waited over 52 weeks for an outpatient appointment. However, after validating the data, it was found that 25,000

records could have been showing that patients were waiting over 52 weeks. The hospital was in the process of validating over 150,000 data entries on the patient-tracking list to ensure they were accurately recording and managing waiting times.

- The service was monitoring its own RTT performance for incomplete pathways as part of their improvement plan. Figures from October 2016 (based on unvalidated data) showed that 69% of patients were seen within 18 weeks. This remained below the national standard of 92%, although performance had improved since March 2016 when only 30% of patients were seen within 18 weeks. Senior managers said the hospital was on track to achieve the trust target of 77% by the end of November 2016, which had been agreed with local clinical commissioning groups. Data provided by the hospital showed that the majority of medical specialities were performing below the national standard of patients seen within 18 weeks of a referral for outpatient services.
- The trust had returned to national reporting of its RTT figures at the end of March 2017 following significant support from NHS Improvement's Intensive Support team. 'RTT Confirm and Challenge' meetings regarding RTT performance were held every two weeks. Data from April 2017 to June 2017 showed actions by speciality, current RTT performance, additional resource updates, and harm reviews.
- During this inspection, we found that, as of 20 June 2017, there were 22,814 patients on the RTT waiting list (both admitted and non-admitted RTT pathways).
- From nationally reported data for May 2017, the trust's overall performance for RTT waiting times was 74%, with half of patients waiting less than 10 weeks and 92% of patients waiting less than 32 weeks.
- There were, as of 20 June 2017, 5,702 patients waiting more than 18 weeks, which indicated the trust was achieving performance of 75% against its own overarching target of 92% (for both admitted and non-admitted RTT pathways). This was marginally below the trust's trajectory for improvement target, which was 77%. The hospital was on track to achieve the trajectory target by the end of August 2017, which had been agreed with local clinical commissioning group. This represented an improvement in reducing the number of patients waiting on an RTT pathway beyond 18 weeks.
- There were 178 patients (for both admitted and non-admitted RTT pathways) waiting over 52 weeks. This again was an improvement from the last inspection.
- For non-admitted RTT pathways, there were 751 patients waiting over 31 weeks (4.1%) and 28 patients waiting more than 52 weeks (0.2%)
- For admitted RTT pathways, there were 1,059 patients waiting more than 31 weeks (22.9%) and 150 waiting more than 52 weeks (3.2%)
- We saw that the patient record data validation programme had been completed for all patients waiting over 52 weeks as of 20 April 2017.
- The trust was working towards meeting their trajectory to have no patients waiting over 52 weeks by Autumn 2017. Figures reviewed at the time of our inspection showed an increase in number of patients waiting 31 weeks or more from 9% to 27% and an increase in number of patients waiting for 40 weeks of more from 4% to 13%. Senior managers were aware of this rise and were taking actions to deal with this increase via the 'RTT Confirm and Challenge' meetings, where performance was reviewed and the actions agreed to continue to improve performance. This included the use of an external organisation to undertake some appointments and treatments required as well as weekend clinics in some specialties.
- Referrals were prioritised by clinical urgency: suspected cancer referrals first, then urgent referrals and then routine referrals on a 'next in turn' basis. Suspected cancer and urgent referrals did not experience any delays in accessing appointments. The maximum waiting time for suspected cancer referrals is two weeks from the day a patient's appointment is booked through the NHS e-referral service,or when the hospital or service receives the referral letter.
- From nationally reported data for May 2017, the service was performing better than the national operational standards for all types of cancer referrals:
  - The trust performance was 97% for the two week wait from GP urgent referral to the first consultant appointment (better than the operational standard of 93%).
  - The trust performance was 97% for the two week wait breast symptomatic (where cancer was not initially suspected) from GP urgent referral to first consultant appointment (better than the operational standard of 93%).

  - The trust performance was 100% for one month wait (31 days) from a decision to treat to a first treatment for cancer (better than the operational standard of 96%).
  - The trust performance was 89% for the two month wait from GP urgent referral to a first treatment for cancer (better than the operational standard of 85%).
- Data provided by the trust showed the following specialities were performing above the 92% national standard of patients seen within 18 weeks of a referral to the service:
  - Clinical haematology: 99%
  - Medical/clinical oncology: 100%
  - Paediatric diabetic medicine: 100%
  - Dermatology: 96%
  - Stroke medicine: 100%
  - Rheumatology: 98%
- Data reported nationally for May 2017 showed that the majority of specialities were performing below the national standard of patients seen within 18 weeks of a referral for outpatient services. Performance at the time of inspection was:
  - General surgery: 58%
  - Urology: 53%
  - Ophthalmology: 64%
  - Trauma and orthopaedics: 72%
  - Oral surgery: 78%
  - Plastic surgery: 81%
  - Gastroenterology: 65%
  - Geriatric medicine: 68%
  - Ear Nose and Throat: 81%
  - Cardiology: 77%
  - Thoracic medicine: 80%
  - Neurology: 85%
  - Geriatric medicine: 75%
  - Gynaecology: 87%
- During our inspection in October 2016, we saw that the outpatients' department did not always have the capacity to run additional clinics to meet the demands of the service. This had improved since March 2017. The hospital's action plan for reducing their waiting lists included running additional clinics and in sourcing a private provider to run additional clinics to meet the demand for outpatient services. The private provider ran additional weekend clinics to bring down the ophthalmology, general surgery, and urology waiting lists, and the length of time patients had to wait. The private provider had run 634 additional clinics by the time of our inspection.
- The trust's policy for prioritisation showed the RTT clock started on the date the trust received the referral and stopped when a patient had either received treatment in an outpatient setting or was admitted for treatment. The RTT clock stopped for non-treatment when a decision was made and communicated to the patient and their GP that; a clinical decision had been made not to treat, a patient did not attend their appointment which resulted in the patient being discharged, a patient declined treatment after being offered it, or a patient died before treatment.
- In order to help teams reduce waiting times, an elective care e-learning programme to help teams reduce waiting times and improve access was launched by the trust in June 2017. Data provided by the trust showed 93% of staff had attended this training by the start of July, with the other staff booked onto this training. The trust's RTT training prospectus from June 2017 to August 2017 covered basic navigation to the electronic recording system (Patient Administration System) and included how to search for patient records, check key demographic information and alerts.

Meeting people's individual needs

- We did not inspect this element.

Learning from complaints and concerns

- We did not inspect this element.

Are outpatient and diagnostic imaging services well-led?

As we only inspected parts of this key question, we have not rated it.

We found areas that:

- Managers in the service now had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen.

- This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings.
- Governance and risk oversight had improved so that the trust's Board of Directors, and all external stakeholders, could be assured as to the trust's ongoing RTT performance and potential risks to patient safety.
- The trust had recruited its own team of data validators.

Leadership of service

- At the October 2016 inspection, we found that the service was led by operational leads and clinical leads who had worked in the hospital for many years. They managed the service across all four sites. Some, but not all, leaders understood the challenges to good quality care and identified actions needed to address them but lacked capacity to drive improvements in a timely way.
- Since the last inspection, the service had recruited a clinical harm coordinator in January 2017 and their role was to lead the harm review process. Patient pathway managers and service support managers were newly recruited to support service delivery and to sustain improvements. Service support managers were now trained to validate patient records and Referral to treatment (RTT) data.
- Managers in the service now had an effective oversight of the hospital's RTT performance and could clearly show how the recording system worked and the number of patients waiting to be seen. This improvement in understanding the hospital's RTT position had been led by the trust's chief operating officer (COO), who drove improvements and checked performance against agreed actions at the service's two weekly 'RTT Confirm and Challenge' meetings. Clear, ongoing communication with NHS improvement (NHSI) and the local clinical commissioning groups (CCG) was evident.

Vision and strategy for this service

- We did not inspect this element.

Governance, risk management and quality measurement

- Senior staff said that the service was well represented at board level. The COO was the executive lead for the outpatient quality improvement programme. We saw evidence that regular reviews were held to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department. Clinical staff carried out clinical harm reviews (CHRs) for patients who had been waiting over 52 weeks. Data provided by the trust showed CHRs were carried out in high-risk specialties after 46 weeks. Senior staff we spoke with said there was a weekly report for patients waiting over 46 weeks and for the trust's executive team.
- We reviewed the chronology of the trust's identification of potential RTT performance issues since March 2014: actions taken included an internal auditors' report on RTT issues presented to the trust's Audit Committee in December 2014. In January 2015, an internal trust report to the Trust Management Committee (TMC) from the COO requested resources to improve the trust's RTT position. The TMC was informed that a review of the data quality issues had confirmed some 45,000 patients records on the trust's electronic RTT management system remained "open" (with no clock start dates in the system meaning the RTT pathways were unresolved despite active treatment having been provided in the past and subsequent treatment episodes recorded as active on this electronic system). In March 2015, the trust's audit committee reviewed the second audit of the RTT data, which contained recommendations to improve assurance operational processes and the findings highlighted lack of knowledge, training for staff, and system weaknesses. In April 2015, an RTT risk assessment was presented to the trust's 'Risk Management Steering Group' by the deputy COO and the trust's Board of Directors discussed RTT non-compliance and opportunities to outsource some services to improve performance. External data validators started working in the trust in June 2015. In July 2015, the National Intensive Support Team (IST) reviewed and approved the RTT recovery plan.
- In November 2015, the trust's Board reviewed a report relating to RTT performance. The trust secured interim support from an RTT specialist from the IST on a full-time basis from January 2016 for six months as well from a data validation expert as there was a requirement to validate up to 46,000 patient records.
- In December 2015, the 'RTT Executive Assurance Group' was established and was chaired by Chief Operating Officer with the CCG attending. The trust's medical director reported at this meeting that eight patients' records that had been found to have waiting longer than 52 weeks on an RTT pathway (as first found in August

2015) had been reviewed as the start of a clinical harm review process. An independent review of these eight patient's records was also carried out by the CCG on 21 January 2016.

- In January 2016, the IST commenced working with the trust on RTT performance. The trust's first clinical harm review process procedure was implemented on 26 February 2016 (and later updated on 9 June 2016). Clinical harm reviews commended on 29 February 2016. In March 2016, an audit by external auditors was presented to the trust which highlighted RTT system weakness and actions to be taken. In May 2016, an external organisation was engaged to enable the trust to clarify, plan and assure the restoration of reporting status in respect of the return to national reporting of RTT performance.
- In May 2016, the clinical harm and governance process for the RTT pathway was approved through the 'RTT Executive Assurance Group'. This meeting was attended by NHS England, NHSI, and the local CCGs. An RTT dashboard was implemented in May 2016 and this included RTT performance and data for the clinical harms completed and for those outstanding. This dashboard was circulated to all relevant departments in the hospital and to the CGG and NHSI who also attended the 'External Assurance Meetings' which initially were held monthly, then became bi-monthly meetings. Representatives from local GP practices also attended these assurance meetings.
- We saw that the following governance and assurance framework was established:

1. 'RTT Executive Assurance Group' bi-weekly meetings with the trust, NHS England, NHSI and the local CCGs.
2. Monthly reports to the trust's Board of Directors.
3. Monthly reports to the trust's performance, finance and resources committees.
4. Trust attendance at monthly Progress Review Meetings with NHSI with RTT performance updates provided.
5. Trust attendance at quarterly meetings with NHSI with RTT performance updates provided.

- The service held two weekly 'RTT Confirm and Challenge' meetings, chaired by the deputy COO. The meetings were previously called the 'RTT Operational Group Meeting'**.** We reviewed minutes of these meetings held from October 2016 to June 2017. There were no minutes for the meetings held on the 14 November 2016 and 07 February 2017. Senior managers told us this was because these were small group discussion and not full meetings. We saw there were clear discussions about performance, data validations, actions required to improve performance and clinical harm reviews that had been carried out.
- We reviewed the recent dashboards for the service and this dashboard gave clear information as to the overall RTT performance positions, individual speciality performance, the number of patients on a waiting list and for how long, the number of clinical harm reviews carried out, and those yet to be done (with the rationale as to why there was any delay).
- External validators stopped working in the trust at the start of June 2017, as the trust had appointed its data validation team comprising of one whole time equivalent (WTE) manager, one WTE validation team manager, one WTE data quality and training lead and nine WTE data validators.
- The trust held a Patient Safety Lessons Learnt Forum every six to eight weeks and this was a multi-disciplinary forum, including staff from the outpatients' service. Learning was taken back to teams for wider organisational learning.
- On conclusion of all serious incident investigation reports, learning was summarised under the trust's values in a news bulletin for all staff. The patient safety team ensured that within one week of the finalised investigation, the learning bulletin was placed in the staff area of the ward/department involved. Additionally, on a bi-monthly basis, the trust was implementing a learning presentation and information board to be displayed in staff areas to engage staff on learning (informed by the bulletins) on a trust-wide basis.

Culture within the service

- We did not inspect this element.

Public engagement

- We did not inspect this element.

Staff engagement

- We did not inspect this element.

Innovation, improvement and sustainability

- We did not inspect this element.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital SHOULD take to improve

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