Care Quality Commission

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough City 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.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care	Requires improvement
Services for children and young people	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Peterborough and Stamford Hospitals NHS Foundation Trust was one of the first wave of NHS trusts to be authorised as a foundation trust in April 2004. The trust has approximately 633 beds and over 3,500 staff spread across two sites, Peterborough City Hospital (611 beds) and Stamford Hospital (22 beds). Peterborough City Hospital is a new building funded under the private finance initiative (PFI); it became fully operational only in December 2010, combining services previously supported on three separate sites. It provides acute health services to patients in Peterborough, Cambridgeshire and Lincolnshire.

In addition, the trust provides a range of community services including community midwifery and Macmillan nursing as well as domiciliary visits undertaken by consultants. The trust provides rheumatology and neurology services at the City Care Centre and services in support of Sue Ryder in Peterborough, at HMP Peterborough and in local GP practices. We did not inspect these services during this inspection.

This was a follow up inspection to the comprehensive inspection of March 2014. This inspection was focused and specifically considered the core services of urgent care and medicine and looked at all key questions and considered the responsiveness of children's services as well as the effectiveness in end of life services. The inspection took place on the 18th and 19th May 2015.

Overall we found a trust that is improving and had addressed most of the issues we noted during our inspection in March 2014.

Our key findings were as follows:

- There had been a recent improvement in the performance of the emergency department against the four hour wait and treatment target.
- A new medical admissions unit had improved patient access and flow through the emergency department and the rest of the hospital whilst also reducing the numbers of outliers.
- Safeguarding procedures in the emergency department were more robust with appropriate checks made by staff regarding children's attendance in the department.
- Medical and nursing staffing had improved across the clinical areas we inspected since our last inspection in 2014 but there remained shortfalls in some areas and there had been an acuity review during this period with an uplift in staff in some areas.
- There were some concerns about storage of medicines in medical wards, specifically the monitoring of temperatures.
- Whilst there was evidence of a learning culture, this was not embedded across the whole of the medical directorate.
- Leadership was visible at trust and directorate level. Most staff felt valued and supported by their managers.
- The majority of staff were caring and compassionate when providing care and treatment but we observed a small number of interactions that were not caring.
- The service had made significant improvements in relation to the provision of same sex accommodation and services for adolescents. The service had engaged adolescents in service development and improvement. We saw a number of patient feedback stories from adolescents giving their opinions on the service, one of these had even been presented to the trust board.
- The Amber Care Bundle had been successfully rolled out to all areas and there was a more consistent approach to managing pain relief in end of life care patients.

We saw several areas of outstanding practice including:

- The trust had thoughtfully engaged with children and young people in the service development and improvement of children's services.

Summary of findings

- A new transition projected had been agreed and was being supported by a CQUIN target for this year called “Ready Steady Go”. This project aimed to build confidence and the understanding of children, younger people and their families’ when transitioning into adult services.
- The trust was now meeting face to face increasing numbers of patients to discuss concerns or complaints.
- The Quality Assurance Committee was open to some external stakeholders including Healthwatch.

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

Importantly, the trust must:

- Ensure records are accurate and updated to reflect the needs of patients and that care is given in line with records.

In addition the trust should:

- Ensure that learning from incidents is disseminated consistently across the medical directorate.
- Ensure that patients are adequately supported with nutritional needs on medical wards.
- Ensure that medicines are stored correctly in all areas.
- Ensure that call bells are answered in a timely way.
  - The trust should ensure that there are appropriate measures in place to further reduce falls and pressure ulcers.
  - The trust should ensure effective admission to the stroke unit for patients requiring specialist care.

Professor Sir Mike Richards
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	Good 	At our previous visit in March 2014 we found some areas of urgent care that required improvement. This inspection was to review and report on those issues. In 2015 the trust was meeting the four hour waiting time target for treatment and discharge from emergency department (ED). The performance on this target was improved due to the implementation of a medical admissions unit two weeks prior to our visit. In the quarter January to March 2015 the Trust had seen 84% of the 21,867 patients within four hours against the target of 95%. The Trust had improved patient flow through the hospital to achieve the target in the weeks prior to our visit. Activity was recorded in detail and showed approximately 7% increase on the previous year at the time of our visit. Medical and nurse staffing had been improved since our last visit. A review had been undertaken to revise the nurse staff complement. There was still much use made of agency nursing staff but this was to ensure safe staffing. Locum cover for consultants was minimal due to effective recruitment into senior posts. Arrangements to care for children had been improved since our last visit. There was a designated paediatric area. This was closed after 9:30pm with children moving to main ED bays. There was only two paediatric registered nursing staff in the ED however, other staff received additional training to mitigate the risk. There were checks made of children under five attending against social services risk databases. Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.
Medical care	Requires improvement 	In 2015 we returned to this service to follow up on issues identified at our last inspection. In 2014 the service was found to require improvement in relation to all five domains. In 2015 we found that whilst some improvements had been made to focus

Summary of findings

on aspects such as falls prevention, pressure ulcer care and patient flow there still remained areas of concern which resulted in the service still requiring improvement in all areas. Incidents remained high, with learning not widespread, records, documentation and medicine storage required improvement. Timely admission to the stroke unit remained an issue as did consultant staffing and auditing within the respiratory service. There were also some incidences of poor interactions between staff groups and staff and patients.

Services for children and young people

Good

In 2014 we found that children's and young people's services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.Children's care and treatment followed best practice guidance and monthly audits were carried out regarding patient safety, patient experience and the environment. Parents we spoke with told us that they felt that their child received good-quality care and that they were informed about any treatment required.

In 2014 we found that staff were responsive to people's individual needs; however, staff were unaware of the trusts guidance for staff on the ward areas when they needed to make a decision concerning same-sex accommodation. There was also limited support from the child and adolescent mental health services out of hours. There was leadership at all levels within children's and young people's services and staff felt well supported well supported by their managers. A clinical governance frame was also in place.

In 2015 we returned to the service to assess whether or not improvements had been made in relation to the responsive domain where in 2014 the service was found to require improvement. This was specifically in relation adolescent service provision and the use of single sex accommodation. It was also identified that improvements were needed in relation to joint working with child and adolescent mental health services (CAMHS). We found that

these improvements had been made and that the service had worked extremely hard to develop and progress projects and plans to meet the needs of the children and young people using this service.

End of life care

Good

In 2014 we found that the trust had a strong focus on end of life care. The trust had used CQUINs (Commissioning for Quality and Innovation targets agreed with the local commissioning groups) to develop and improve the service provided to patients at the end of their life.

The trust was clear with regard to the actions required to review and replace the Liverpool Care Pathway. The Amber Care Bundle was being piloted on two wards. The action plan demonstrated that it would then be rolled out across the trust to meet the Department of Health's guideline timeframe of July 2014.

The palliative care team was very committed and provided a service seven days a week. The team was alerted immediately to any admission of a terminally ill patient. There was very good multi-agency working and close working with both the community team and the local hospice.

Staff were clear about 'do not resuscitate' policies and documents viewed were appropriately signed. Equipment was available and clean, appropriate checks had been made and staff understood how to use the equipment.

The care provided to those who had died was excellent and led by a very passionate bereavement centre manager. In addition, the chaplaincy service and the faith centre provided support to both patients, their families and friends and staff of all faiths and cultural backgrounds.

The purpose of our follow up inspection in May 2015 was to check that the Amber Care Bundle had been rolled out throughout the trust, that pain management was being prescribed and administered effectively and communication over the preferred place of death had been improved. We found that a new lead for palliative care had been put in place and that they had supported and empowered the palliative care team to drive forward improvements and positive change. This meant that the effective domain had gone from requiring improvement to being rated as good.

Peterborough City Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Services for children and young people; End of life care;

Detailed findings

Contents

Background to Peterborough City Hospital

Peterborough City Hospital has 610 beds and provides medical and surgical services to Peterborough and the surrounding counties. Peterborough City Hospital is a new building funded under the private finance initiative and became fully operational only in December 2010, combining services previously supported on three separate sites.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included five CQC inspectors and four specialists in A&E, medicine, children's services and governance processes.

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 to people's needs?
- Is it well-led?

However at this inspection we reviewed only the areas where Peterborough City Hospital had been rated as requires improvement. These were:

Urgent and Emergency Services : Safe and responsive

Medical care including older peoples care: Safe, effective, caring , responsive and well led

Children's and Young people's services: Responsive

End of life services : Effective

The inspection took place between 18 and 19 May 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor and the local Healthwatch.

Detailed findings

We did not hold a listening event but some people shared their experiences with us via email or by telephone. We also received feedback from the local Healthwatch organisation.

We carried out an announced inspection visit on 18 and 19 May 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff.

We talked with patients and staff from ward areas and urgent care services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Peterborough City Hospital.

Facts and data about Peterborough City Hospital

Key figures:

• **Beds**: 610

– 610 General and acute,

- 23 Maternity

- 16 Critical care beds.

• **Staff**: 3,500

– 438 Medical

– 1,080 Nursing

• **Annual turnover: £250.1m**

• **Surplus (deficit): (£38.5m) as at 31 March 2015**

Activity summary (Acute)

Activity type 2014-15

Inpatient admissions 52,238

Outpatient (total attendances) 402,808

Accident & Emergency 93,500 (attendances)

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Services for children and young people	N/A	N/A	N/A	Good	N/A	Good
End of life care	N/A	Good	N/A	N/A	N/A	Good
Overall	Good	Good	Good	Good	Good	Good

Detailed findings

Notes

In our inspection report of 2014 we were not rating effectiveness within the Urgent and Emergency care services. At this inspection we reviewed all key lines of enquiry and feel now able to rate this element.

Urgent and emergency services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Emergency Department is made up of major injuries (majors) including rapid assessment bays, minor injuries (minors), the paediatric area, and a resuscitation area. There were triage rooms where patients had initial assessment after checking in at the waiting room reception.

The Trust has a separate waiting area for children with a route through to the designated children's emergency rooms without passing through the main waiting area. This was open from 9am to 9:30pm with children being cared for in other main ED areas outside of these times. There is a separate paediatric bay within the resuscitation area.

Next to the Emergency Department was the Medical Assessment Unit. This had been open just two weeks prior to our visit. Patients attending directly from their GP were assessed as safe to be transferred and then taken straight to this unit for detailed assessment by the medical teams and later admission. Stay on the unit was for just 24 to 48 hours for the assessment, diagnostic tests, and stabilisation of condition if needed. Some patients on the admission unit were managed by doctors from the Emergency Department if they were expected to be discharged after stabilisation or test results.

We spoke with 14 staff and 10 patients and relatives, including on the Medical Admission Unit.

Summary of findings

At our previous visit in March 2014 we found some areas of urgent care that required improvement. This inspection was to review and report on those issues.

The Trust was at the time of our visit meeting the four hour waiting time target for treatment and discharge from Emergency Department (ED). The performance on this target was improved due to the implementation of a Medical Assessment Unit two weeks prior to our visit. In the quarter January to March 2015 the Trust had seen 84% of the 21,867 patients within four hours against the target of 95%. The Trust had improved patient flow through the hospital to achieve the target in the weeks prior to our visit. Activity was recorded in detail and showed approximately 7% increase on the previous year at the time of our visit.

Medical and nurse staffing had been improved since our last visit with recruitment to a number of posts.

A review had been undertaken to revise the nurse staff complement. There was still a high use of agency nursing staff but this was to ensure safe staffing. Locum cover for consultants was minimal due to effective recruitment into senior posts.

Arrangements to care for children had been improved since our last visit. There was a designated paediatric area. This was closed after 9:30pm with children moving to main ED bays. There were only two paediatric registered nursing staff in the ED. There were checks

Urgent and emergency services

made of children under five attending against social services risk databases. However the bespoke risk assessment checklist for safeguarding children of all ages was not completed in around 80% of cases.

Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.

Are urgent and emergency services safe?

Good

Incidents were appropriately reported and investigated with learning feedback given to staff. Mortality and morbidity meetings were held monthly to identify key learning. The department was clean with good infection control practices by staff. In 2014 we had reported concerns identified in safeguarding children and checking child protection registers. In 2015 we saw that this had been addressed with a more robust system in operation.

There had been on-going recruitment of nursing staff in the department though there was still significant vacancies being supported by agency and bank staff. The department was not always meeting national guidance in relation to paediatric nursing support in the emergency department however the risks to patient safety had been mitigated through increasing the skills of nurses in the Emergency Department, including extra training in children's nursing and paediatric life support, and access to paediatric advice and support from the children's ward staff.

Safety in the past

The Emergency Department had systems in place for recording and monitoring performance. A dashboard was used to rate performance against key indicators and performance was colour-coded as red, amber or green to enable management to see at a glance those areas that required improvement.

In 2014 we reported that during a 13 month period from July 2012 to July 2013, there was a total of 302 incidents reported to the National Reporting and Learning System by the hospital: these included seven "moderate harm" incidents. Other incidents reported during this period were categorised as minor or insignificant or as having had no adverse outcome. Patients either admitted with a pressure sore or acquiring a pressure sore within the first 72 hours of admission accounted for the highest number of incidents (in approximately half of these, there was an indicator that the patient had been admitted with the

sore). These are reported by the Trust but attributed to the community. Patients experiencing a delay in their treatment comprised the second highest number of incidents.

In 2015 we found there had been six serious incidents relating to the Emergency Department in the past year from May 2014. We looked at the serious investigation reports from incidents and saw that there had been full investigations. Mortality and morbidity meetings were held monthly with reporting into the clinical management and governance meeting for the department. All staff were aware of the Duty of Candour regulations.

In 2015 other patient safety indicators were monitored, for example the National Early Warning System (NEWS) and the Paediatric Early Warning System (PEWS). These are tools designed to help nurses monitor whether a patient may be experiencing a sudden decline, and they aim to improve patients' clinical care. We saw that compliance with using the monitoring tool for adults had not been met for quarter 3 but had been met in January 2014. Overall achievement was much lower for paediatric patients: the target had been met for October 2013 but not since.

Learning and improvement

In 2014 incidents were reported using an online tool. The staff we spoke with told us that they reported incidents they may have been involved in or witnessed. Staff told us that they were confident in using the system and were encouraged to report incidents as they occurred.

The staff we spoke with told us that they had learned from incidents once the investigation into the incident had been completed. Staff told us that they received feedback directly from the matron about some of the incidents they had reported; we saw examples of this.

We were told that lessons from serious incidents were shared and communicated through various meetings within the department, the directorate or the trust, depending on the nature of the incident. We were told that incidents relevant to the Emergency Department were discussed at staff briefing meetings and senior nurses meetings; we were shown examples of minutes from these.

We reviewed the investigation into a serious incident that had occurred in 2013. The report detailed a chronology of events, considered the learning points and listed recommendations in response to the findings. The investigation was supported by an action plan, and the plan indicated that actions for completion by the Emergency Department had been implemented.

Systems, processes and practices

We observed that the design and layout of the department were conducive to providing care to patients in accordance with their needs. The department was visibly clean on the day of our inspection and the department scored highly in cleaning and hand-washing audits.

In 2015 we found there was good prevention and control of infection, the department was visibly clean and well-ordered and that we saw staff used appropriate personal protective equipment. There was safe management of medicines and we saw that medicines were stored correctly and securely and that medicines that required refrigeration were kept a temperature checked fridge.

Staff had access to IT systems that enabled them to track patients, report incidents and access policies, among other things. We were told by staff that equipment was always available and well maintained. We observed that the resuscitation trollies contained all the required equipment.

In 2014 the hospital had systems in place to ensure that safeguarding concerns were shared with the relevant local authorities' safeguarding team. A dual system was in operation to share concerns: if a member of staff suspected that a child or vulnerable adult may have been subject to abuse, they would make a direct referral to the relevant safeguarding team. If they had concerns about a child's general welfare, they could complete a 'cause for concern' form; we saw examples of this happening. In addition to the above reporting arrangements, children under the age of five were routinely checked to establish whether they were on the local authorities' child protection register. However, responsibilities for making checks had changed recently and staff were not clear about who was responsible for making them. The records we reviewed for children under five who had attended the Emergency Department had not been checked against the child protection register in accordance with the hospital's policy.

Urgent and emergency services

In 2015 there were procedures to respond to signs or allegations of abuse. The systems for safeguarding of children were in place but could be more timely when checking children over five years of age. There were potential delays in the checking of children against 'at risk' registers. The hospital serves Peterborough and the surrounding counties. When a child attended from the Peterborough or Cambridgeshire area the register was checked automatically by the clerk on registration as there were electronic links to social services database. However for many children who attend from other counties the register would be checked on the next working day. We received advice from a CQC specialist advisor who told us that this was acceptable practice.

In 2014 clinical records for children included a checklist to remind staff to assess the risk of abuse to children. Staff advised that they would complete this assessment for children of all ages. We saw that this checklist was not completed on all the clinical records we reviewed.

In 2015 we found flow of patients through the department had been improved by implementing a Medical Assessment Unit which allowed more space and time to care safely for patients with emergency conditions. Information and data reviewed showed that patients were seen more quickly than previously and the department was performing consistently better against the four hour target for admission and treatment.

Monitoring safety and responding to risk

Staffing was monitored throughout the day and a daily staffing sheet was used to record staff allocations. Shortfalls were addressed by the nurse in charge in the first instance and bank and agency cover obtained as required. If cover could not be sourced, this was escalated to the Lead Nurse and subsequently to the directorate operational lead for that area. The situation would then be assessed and staff moved within the department according to demand and associated risk.

In 2014 the department was fully staffed for healthcare assistants but had a vacancy rate of approximately 10% for nursing staff. Approximately 7% of nurses were also on maternity leave. This meant that the department frequently relied on bank and agency nurses to provide cover. We were told that recruitment of nurses for the emergency department was on-going and that new initiatives were being considered to reduce the number of vacancies; these included the recruitment of nurses from abroad which was currently taking place.

In 2014 the trust had seen a dramatic improvement in consultant posts being filled within the department during the past 18 months. The lead clinician had developed a recruitment campaign and we were informed that six consultants were currently in post with a seventh post having been successfully filled. The deanery had advised the department that it needed an additional two consultant posts and a business case was being prepared to request these. The staff we spoke with had mixed opinions about whether the department was adequately staffed. Some staff thought that the department could become very busy and that they did not always have sufficient staff on duty. Other staff told us that there were adequate staffing arrangements in place. During our visits we found that the department was busy but adequately staffed.

In 2014 we saw that the number of 'safe staffing level' incidents reported had increased from two in quarter 1 to 11 in quarter 3, with the highest number of 'safe staffing level' incidents reported in November 2013. We were informed by the matron that if a member of staff reported a staffing shortfall it did not always mean that the department was unsafe: this was because cover may have been sourced after the staffing incident had been reported. We reviewed the nursing rotas for November and December 2013 and found that, according to the rotas, there was a shortfall in staff for most shifts in November.

December 2013 was much improved, with almost all of the shifts having the required number of nurses and healthcare assistants in accordance with the departments agreed levels.

In 2015 we found the staffing levels were appropriate to cover the different areas of the department. We saw that patients were always appropriately monitored and supported. Staff requirements had been reviewed and expected levels had been increased to match the revised department layout. There had been a 40% vacancy rate but this had been reduced due to recruitment. There were approximately 80 registered nurses with 21

vacancies at the time of our visit. This vacancy included additional staff to meet the estimated needs for the new arrangements and uplift in staffing numbers. There was an on-going recruitment programme for staff.

In 2015 the nursing staff levels were supported by agency and bank staff. In February to April 2015 there were up to 15 agency staff on each 24 hour period with around 3500 hours covered each month by bank and agency registered nursing staff. This equates to over 70 twelve hour shifts covered per week. There were on-going efforts to recruit staff including experienced nurses from abroad.

Children should ideally be cared for in an area separate to the adult ED patients. At the time of our visit in 2015 the paediatric area was open from 9am and closed at 9:30pm. Children were then moved or treated in the main minor's area. This was to improve monitoring and maintain safety through the night. A survey of children's attendance had shown children were still in the department until after midnight. This had been noted by managers and we were informed that they planned to keep the children's area open until midnight from July 2015. There were only two paediatric registered nurses on the team for the ED. This meant that general ED nurses cared for children without paediatric support immediately available. There was a paediatric assessment unit next to the ED for advice when needed.

In 2015 there was consultant presence in the ED until 2am with middle grade medical staffing through the night. There were two consultants through the day and two on the late shift. There were plans to ensure the rapid assessment bays were supported by consultant medical staff. Due to effective consultant and middle grade recruitment there were sufficient consultants to cover and provide for senior clinical decision making. There were systems in place to support and mentor medical staff, and provide review and check of clinical records and diagnostic reports.There was safe medical staffing cover in the ED. Locums were used to cover shifts to maintain adequate staffing. There had been effective recruitment of consultant staff meaning consistent senior support. In February to March 2015 only 377 hours were required to be covered by locums at consultant level, out of a total of 4,773 hours for all medical staff locums.

In 2014 we spoke with staff about safeguarding policies and procedures. The staff we spoke with all talked confidently about how to recognise the different types of abuse and what they would do if they suspected that a vulnerable person may have been subject to some form of abuse. We observed patient handovers and found that suitable information was transferred between staff during handovers.

In 2015 one patient we spoke with told us some concerning information about their care. We discussed this safeguarding issue with the ward manager who said they would follow Trust procedures for reporting. Senior managers told us that these concerns had already been raised with the matron for the area, investigated and were unsubstantiated.

Anticipation and planning

In 2014 we found the trust had an internal major incident plan, developed in accordance with the Civil Contingencies Act 2004. The plan set out internal responsibilities and links with external services; each delegated role was supported by a separate action card that specified individual responsibilities. The hospital was also a training centre for major incidents and took part in practical exercises every three years as well as annual theoretical exercises. The most recent practical exercise was undertaken in November 2013, after which an action plan was developed to make improvements for future exercises or eventualities.

In 2014 during the preceding 12 months, one major incident had occurred. An incident report had been written following the event, detailing the timing of events and actions taken. An operational debrief had taken place and perceived strengths and weaknesses had been documented. The Emergency Department had a separate escalation policy to cope with a large influx of patients, as well as for dealing with relocation issues in the event that a particular area within the department could not be used. The plans set out clear lines of responsibility and actions to follow. A proportion of the staff working in the emergency department was currently funded and employed by the military. This arrangement was due to cease in July 2014 and the trust was aware of the need to increase its number of staff and fund these positions. We were told that the staffing levels within the emergency department would remain the same and that there was a trust-wide plan to provide for this.

In 2015 we found there were clear patient flow and assessment processes in place. All patients including children who attend as emergencies were assessed by a

triage nurse or an experienced nurse receiving patients from ambulance staff. Patients attending by ambulance were assessed in a rapid assessment bay then taken through to the appropriate bay in majors, or medical assessment unit or other area such as minors as needed. This meant patient's conditions were assessed appropriately and made safe prior to waiting for medical assessment and treatment.

In 2015 patient observations included the early warning score for patient's condition. This was recorded on observation charts with a specific paediatric version on children's charts. Senior staff and medical staff were advised if the score changed indicating deterioration in the patient's condition. The service had audited the completion scores on records. Adult score completion had reduced from 90% to 70% from September 2014 to March 2015. The Paediatric Early Warning Score (PEW's) completion had reduced from 100% to 63% from December 2014 to March 2015. This had been raised at governance meetings with resulting reminders to staff to maintain monitoring for adults and children.

In 2015 the ED staff implemented a regular check on patients who needed to stay in the department for more than four hours. The checklist included checking for pain, hydration, position and skin integrity. Staff noted that this had not been used since the medical admission unit had opened two weeks prior to our visit. Patients who were elderly with complex needs or who were frail were cared for by the team responsible for care of frail and elderly patients from the medical admission unit. There were 49 beds on the unit allowing such patients to be fast tracked from ED for review by this team. The department had focussed on improving the antibiotic support for patients. Governance processes had led to additional information and reminders to medical staff to check and provide treatment for patients to avoid the risk of sepsis.

In 2015 results of x-rays that showed an abnormality were all reported to consultants for checking and follow up treatment. When patients left without being seen after having diagnostic tests such as x-rays the results were checked by a consultant to ensure patients were recalled if there was a clinical need.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

In 2015 we found that the department practice was evidence based and following national guidance and standards. Local and national audits were carried out to measure outcomes and identify areas for improvement which were acted upon. The unplanned readmission rate was slightly worse than the England average. Medical and nursing staff told us they were well supported in their work and received regular appraisals and teaching. There was effective multidisciplinary working, particularly with the new medical assessment unit, to improve the patient journey through urgent care services.

Evidence-based guidance

In 2014 we found that a clinical audit plan had been developed that would run over a three-year cycle; 2013/14 was to be year one. The audit plan for the current year included four audits: three had not yet started as there had been a delay in receiving guidance from the College of Emergency Medicine. An audit on transient loss of consciousness had been completed; this was to establish whether guidance set by the National Institute for Health and Care Excellence (NICE) had been followed. Results were awaited at the time of our visit. A further four audits were scheduled for years two and three of the audit plan. Two audits, as well as a clinical audit plan, had been agreed for August 2013. The hospital had an urgent care action plan that reflected external audits of issues within the department. The trust had invited the national Emergency Care Intensive Support Team (ECIST) to review its systems and processes in the ED to help improvements continue and to assist in achieving the 4 hour targets set f or treatment for patients.

The Emergency Department had developed fast-track pathways for a number of specialist areas, including diabetes, nutrition, cardiac arrhythmia and neutropenic sepsis. We reviewed a sample of patient files against selected protocols and found that patients had been treated promptly and in accordance with the correct protocols.

In 2015 we found there were good arrangements to provide and to audit care and treatment based on best practice and according to national evidence-based

standards and guidelines. The ED was the trauma unit in the region so standard procedures for managing patients with severe trauma were used from a regional manual (TEMPO) that all other units used.There was a checklist for patients with fracture of the hip. However there was no comprehensive fast track system for these patients.

In 2015 care was provided using 'Clinical Standards for Emergency Departments' guidelines produced by the Royal College of Emergency Medicine (RCEM). There was routine audit of standards to check performance with feedback to teams through clinical governance meetings and staff briefings. The ED consultants reviewed and revised pathways of treatment such as for a limping or fitting child or NICE guidance on head injury to meet national standards.

Monitoring and improvement of outcomes

In 2014 the emergency department monitored trust-wide targets, some of which were set nationally and others through local agreement: these included targets relating to infection rates, the number of falls, the number of incidents and complaints.

Data for the above was collated monthly and summarised on a balanced scorecard. Performance was reviewed and discussed at meetings in accordance with the committee structure. Operational staff within the department were kept informed through the team briefings.

In 2015 we found audits were undertaken in 2014 to review performance against the RCEM standards. Older People Care in Emergency Departments, Severe Trauma TARN (Trauma Audit & Research Network), Mental Health Care in Emergency Departments and Initial management of the fitting child. There were plans for the audit in 2015 of sedation in adults, vital signs in children and the risk of clot formation in lower limb immobilisation.

In 2015 we reviewed RCEM audit results for 2014/2015. For management of the fitting child, the emergency department was in the upper quartile for the fundamental standard related to blood glucose monitoring meaning it was amongst the best results in the country. Other results were broadly in line or slightly better than other emergency departments with only one benchmark being in the lower quartile (children being given antipyretics).

The RCEM audit for mental health showed that the emergency department was close to or at the upper quartile for two fundamental standards but was at the lower quartile for one standard (provisional diagnosis recorded).

The RCEM audit for assessing cognitive impairment for older people showed the emergency department to be above the lower quartile for one fundamental standard. Other results were mostly in the upper quartile of results and so better than many other emergency departments.

Trauma audit results showed that in 2013/14 there was an improvement in survival rate of the severely injured patients attending the Peterborough ED patients compared to 2011/12 and this was above the national average.

The unplanned re-attendance rate within seven days for the ED showed that the trust was performing just above the target of 5% for the year to February 2015 at 5.8%.

Staffing

In 2014 we were told that staff had annual appraisals. The staff we spoke to told us that they felt supported by management and found their appraisal a helpful process. We were shown evidence that 66% of staff within the directorate had completed their appraisal for the year. Staff had mixed views about the training they had completed. Staff talked confidently about safeguarding arrangements but had less knowledge of other aspects of patient care, for example caring for people with dementia. We reviewed training records and found mixed results across mandatory training subjects. We saw that some mandatory training sessions had high attendance and completion rates: for example, safeguarding children training had been well attended by all staffing groups. Other mandatory training sessions, for example adult basic life support, had been completed by 39% of medical staff but by 93% of other staff working within the emergency department. Medical staff had undertaken Advanced Life Support training which includes Basic Life Support at induction. Training in moving and handling had not been attended by any medical staff; equality, diversity and human rights also had a low attendance rate among the medical staff but had been well attended by other staff.

In 2014 staff we spoke with were aware of the Mental Capacity Act and associated deprivation of liberty

safeguards; most staff told us that they had completed training in this area. Staff responses were mixed about whether they had completed training on supporting people with dementia.

In 2015 we found medical staff were well supported and followed an induction and training programme. Induction training included infection control, management of blood transfusions and safeguarding arrangements for adults and children who may be vulnerable. New medical staff were supernumerary until competence had been tested. Medical staff used workplace based assessment booklets to check and record competence.

In 2015 consultants and other medical staff said that they mentor and worked together on audits against clinical guidelines to develop awareness and improve adherence to standards.Ten nursing staff were emergency nurse practitioners and another ten were experienced staff who could take coordination roles when on duty. There were over 60 other registered nurses in the ED team. There was also a clinical educator member of staff who supported competency checks and ensured adequate induction of new staff.

Multidisciplinary working and support

In 2014 we observed handovers between shifts and found that information shared between staff changing shifts was adequate to ensure patient safety.

The mental health crisis team was contacted for adult patients who attended the Emergency Department due to mental health needs. This service is run by the local mental health trust. The crisis team attended once the patient had been stabilised. We were told that there was frequently a delay in the crisis team attending, and that this may impact on the patient's well-being. We reviewed a sample of patient notes and saw that staff from the emergency department had informed the crisis team of patients in their care but the crisis team had not responded promptly.

Children and young people who attended the Emergency Department with mental health needs were supported by the child and adolescent mental health (CAMHS) team. This service is run by the local mental health trust. We were told that this service was only available during office hours and that there was frequently a delay in the CAMH team responding. This was supported by patient notes and through a conversation with one patient's relative. We were told that the emergency department would admit the child or young person until they had been seen by the CAMH team.

In 2015 we found there was close working and integration between ED and the rest of the hospital. All admissions were assessed in ED at rapid assessment prior to transfer into the medical admission unit. This meant good flexibility to manage patients as either emergency or routine admissions. If there was overflow from the Medical Admissions Unit back into ED the emergency room medical staff managed patients to ensure rapid assessment and treatment.

Are urgent and emergency services caring?

Good

In 2014 we found that most people thought that staff in the emergency department were caring. In 2015 we found that most patients spoke highly of the care they received. We saw positive interactions between patients and staff. Patients told us that they were given information about their condition, care and treatment and that staff answered their questions. The Friends and Family Test for the department had improved since 2014 with 90% of patients recommending the service.

Compassion, dignity and empathy

In 2014 patients in the majors department were accommodated either in side rooms or in beds that were semi-partitioned; this was sufficient to protect their privacy and dignity while enabling staff to observe the patients easily. Staff told us that curtains were always pulled round patients when they received personal care or discussed information. A number of beds on the emergency department were in side rooms, while other beds had a partition wall separating them from other patients. The staff and patients we spoke with liked the layout of the emergency department, which meant that people could be cared for in privacy as well as being observed easily by staff.

Staff working in the Emergency Department did not undertake comfort rounds to ensure that patients had

had their continence needs met, were comfortable and not in any pain, and had a drink if they needed one. We were told that this was because the patients were in the department for only a short time and were well cared for. We observed that call bells were positioned on the wall behind the patients' beds and were not within reach. The patients we spoke with were mostly satisfied with the care they had received; however, two of the patients told us that their continence needs had not been met. Some patients described incidents where care had been protracted and unsatisfactory.

In 2015 we observed staff asking patients about their pain. Staff checked patient comfort, pain levels and we saw that analgesia was administered where needed. Patients told us they were comfortable and had been asked about pain.

Involvement in care

In 2014 most of the patients we spoke with were satisfied with the communication during their time in the Emergency Department. We observed positive interactions between staff and patients although we did observe one member of staff who was abrupt when speaking to a patient. The relative of one patient also told us that some of the doctors could be rude but that the nursing staff had been very caring.

Most patients told us that staff communicated well with them: for example, one patient told us that they had remained in the department for approximately eight hours but that staff had regularly updated them and provided an explanation. This was not always the case: another patient told us that they wanted pain relief but were not able to have any because the hospital did not have sufficient information about them. The patient told us that they did not know what this meant and did not understand why they could not have pain relief.

Most of the patients we spoke with were happy that they were listened to if they asked for something. The relative of one patient told us that their relative was going to be discharged but the relative did not think the patient was well enough to be discharged and so they requested that a specialist should review the patient. This request was granted, the patient was re-evaluated, and both the patient and their relative were satisfied with the outcome.

We spoke to another patient and their relative who were dissatisfied because the patient had been discharged in the early hours of the morning and had been brought back by ambulance two hours later.

In 2015 we spoke with sixteen patients and all said they had been provided with good information and support. Patients were included in their care and supported to make decisions about care and treatment. The most recent NHS inpatient survey results for the trust showed patients felt they were given good information and had sufficient privacy in the ED.

Trust and respect

The NHS Friends and Family Test results show that patients attending the ED were likely to recommend the department to their family and friends. The results in 2014 were significantly above the England average.

When we visited in 2015 the most recent NHS inpatient survey results for the trust showed patients felt they were given good information and had sufficient privacy in ED. The survey from September 2014 and January 2015 was answered by 392 patients at Peterborough and Stamford Hospitals NHS Foundation Trust. Those responses relating to the ED showed eight of ten patients said they were given enough information on their condition and treatment, and nine of ten patients said they were given enough privacy when being examined or treated. The friends and family test for ED had improved from around 50% in April 2104 to 90% in March 2015 for patients who would recommend using the service.

The nursing staff we spoke with told us that they had attended equality and diversity training. One member of staff told us that Peterborough was a multicultural area and that they had an understanding of the different cultures and religious needs.

We observed that patient records were stored securely and that patient notes were written in a clear and concise manner. Care and treatment required were well documented.

In 2014 we saw that discussions between staff and patients were undertaken at their bedside. Side rooms were available for some patients, while others had their privacy and dignity respected because there was a partition between beds and curtains could be pulled round as required.

Urgent and emergency services

In 2015 patients told us they were well informed and supported by staff. Patients we spoke with in cubicles and the waiting area had been given good information about waiting time and their treatment. We saw that triage staff responded quickly to ensure patients had minimal time to wait before seeing a clinical member of staff.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

In 2014 we were concerned at the lack of a separate children's emergency department. In 2015 we saw that this area had been opened and provided an appropriate area for the treatment of children though we were aware that it was only open until 9.30pm. Staff received training in caring for people with learning disabilities but staff told us they had received limited training for caring for patients living with dementia. There was a dedicated team for responding to and caring for frail patients who supported the emergency department.

The department had seen an improvement in its performance against the four hour decision and treatment target year on year but was still below the target for January to March 2015 at 84%. Data we reviewed on inspection showed that the department was recently meeting the 95% target after the opening of the medical assessment unit two weeks prior to our inspection. There were no 12 hour waits for 2014/ 2015.

Meeting people's needs

In 2014 the hospital had not consistently met the national target of all patients attending the emergency department being admitted, transferred or discharged within four hours. Over the previous year the hospital had failed to meet the target on a significant number of occasions. The breach rates were higher for admitted patients; typically, the highest number of breaches were for medical patients, the most likely cause of which was a lack of beds. The second and third most likely causes were long waits for a specialist or waiting for an assessment respectively. We were shown evidence that bed occupancy for medical beds frequently exceeded 90%.

In 2014 the Emergency Department did not meet the target for the number of patients who had left the department without being seen (September 2012 to August 2013), but met the target for patients having their initial assessment within 15 minutes of being brought in by ambulance. The EMU, which was introduced in November 2013, had a proportion of beds on the ESSU. The purpose of the EMU was to assess patients referred by their GP who had a suspected emergency medical condition; once stable, patients could be discharged, admitted for a short stay or transferred to a specialist bed. However, we were told that the beds on the EMU had not been protected and were frequently filled with other medical patients. This impacted on the performance of the Emergency Department because the available beds had not been used for their intended purpose.

In 2014 the trust had set up an internal urgent care board (UCB) with responsibility for overseeing key actions to improve patient flow through the hospital. Meetings were held weekly. We reviewed a sample of action notes and saw that there were different actions for specific work streams. These included actions to establish a surgical assessment unit; actions to improve the timeliness of patient assessments by the Emergency Department team as well as by different specialties; and plans to improve the protection of the number of EMU beds and to improve ward-based discharge arrangements, among other things.

In January to March 2015 the Trust had seen 84% of the 21,867 patients within four hours against the target of 95%. The Trust had improved patient flow through the ED, MAU and the hospital to achieve the target in the weeks prior to our visit. The new MAU had improved patient flow through the ED and also improved discharge times for patients who did not require admission to the hospital. Activity was recorded in detail using a reporting system developed at the Trust. There was real time feedback to department managers and clinicians to show performance against targets and reasons for any delays. We examined detailed analysis for a day during our visit which showed clinical reasons for the delays.

At our inspection in 2015 there had been no breaches of the four hour target for diagnostic reasons in the year to March 2015. The system showed approximately 7% increase on the previous year at the time of our visit but

the level of breaches of the four hour target was less than 2014. Ambulance turnaround times were improved as a result of the Medical Assessment Unit with the hospital performing better than many in the region according to data reviewed. The average time to treatment target which shows how long patients wait for definitive treatment for their condition was within target from February 2015. There were no 12 hour trolley waits in 2014 to 2015 at this service.

In 2014 the hospital did not have a separate Paediatric Emergency Department. There had been a series of external visits to the hospital by the ECIST as well as by the NHS East of England Area team. The final outcome of these visits was the recommendation that a Children's Emergency Department should be re-established because care of children had become fragmented due to the lack of a central unit. We were told that a proposal had been drafted and that it was planned that the paediatric emergency department would be re-established in July 2014.

On inspection in 2015 we saw that there was a separate area for children and young people within the ED which had opened in July 2014. This area was closed after 9:30pm each day and was not always staffed by paediatric trained nurses though Emergency Department staff had additional paediatric training to mitigate this. We saw that in the paediatric emergency care area there were play specialists as part of the team for some shifts. These staff may support children and families during the urgent admission to relieve the stress for the child and encourage rapid compliance by the child with any treatment needed.

In 2014 we were told that patients attending the Emergency Department received a cold meal (usually cereal or a sandwich); this was because they were meant to be in the department for only a short period. We were told that patients did not receive hot meals even if they had been in the department for more than four hours. The patients we spoke to were satisfied that they had received sufficient nutrition and hydration during their visit to the Emergency Department.

In 2015 we found there were good arrangements for staff to provide ED patients with drinks or food if this was required while waiting for treatment or admission.

Access to services

In 2014 we saw the Emergency Department was open 24 hours a day, seven days per week. We were told that the department never 'closed' its doors. If capacity was stretched, the trust would be placed on alert and the hospital's escalation policy would be followed.

In 2015 we found consultant staff were available to provide patient care and advice until 2am each day. The department was staffed at night by the middle grade medical staff within the team rather than using any unfamiliar locum staff.

In 2014 when the hospital was close to capacity, the escalation policy was followed. Staff could observe current capacity using an online patient tracking system; this information was discussed at capacity meetings that were held twice a day routinely, and increased to three times per day as required. The level of concern regarding capacity was rated as green, amber, red or black, with black being the highest state of alert. Black alert was frequently reached.

We were told that patients could access an interpreter service if they were unable to communicate in English; we were also told that a number of staff were able to speak a second language. However, staff were not aware of an advocacy service if patients required an advocate. We were told by the lead for patients with learning disabilities that contact details of an advocacy service were available on the intranet.

In 2015 we saw that the four hour target had been met consistently since the changes in configuration of ED and MAU two weeks prior to our visit. The department had not been meeting the four hour waiting time target for the previous year however we saw that patients were managed appropriately to their needs as quickly and efficiently as possible. Systems were in place to maintain effective flow through to ED or the medical assessment unit. We saw that board rounds were undertaken in the Medical Assessment Unit to ensure active management of patients diagnostic tests and decisions to admit. Staff noted that patients were being placed in the appropriate specialty ward as a result of the assessment period spent on this unit.

In 2015 GP admissions were managed in the assessment unit which meant that part of the ED major's bays were available as overflow areas if required. All patients were

assessed as safe to move across the admission unit when they arrived by ambulance.The trust had also established a separate ambulatory care unit (ACU). This was staffed with experienced nurses and medical staff running clinics. There were five junior nurses, five senior nurses and six advanced nurse practitioners. The staff provided prompt care for urgent and returning patients. Patients were directed to this unit from ED if their condition was stable and suitable for treatment in the unit. Patients attending with suspected thrombosis and low risk chest pain were managed as urgent cases in the ACU. The specialist nursing staff had additional training and competencies to provide technical investigations and procedures, including drainage of fluid from the abdomen and linings of the lung.

Vulnerable patients and capacity

In 2014 the Emergency Department did not have a specialist dementia nurse. We were told that the ESS had one dementia champion who could be contacted when they were working a shift. One member of staff told us: "There is no dementia champion on the emergency department. We could call upstairs to the ward for support but we never have. I haven't completed any training on dementia; we ask the patient's next of kin for support."

Staff told us that if a patient with a learning disability attended the emergency department and they were unable to speak for themselves, the staff would talk to their carer or relative. Staff were unclear about how they would support or communicate with someone if they did not have a carer or relative with them. Staff were also unclear about how to arrange for an advocate for a person. There was no mandatory training for staff on caring for people with a learning disability; however, the disability and equality lead adviser provided ad hoc training to wards or teams of staff if requested.

We spoke to the disability and equality lead adviser who told us that staff could access guidance on the intranet on caring for people with a disability and that this includes details of how to arrange an advocate. We were also told that a new strategy was being drafted to provide staff with guidance on how to care and support people with a disability; this was in the process of being finalised.

In 2014 staff told us that the crisis team would be contacted for adults with mental health needs and the CAMH team would be contacted for children with mental health needs who attended the emergency department. We were told that this did not always work well as the mental health teams did not always respond quickly, so patients frequently had to wait a long time for them to arrive.

In 2015 we found that staff in ED had attended training about the care of patients with learning disabilities but there had been no specific training relating to care of patients living with dementia. We spoke with the dementia specialist nurse for the Trust who provided regular visits and support to the Medical Assessment Unit. There was also a team responsible for care of the frail and elderly based in the adjacent admissions unit for support. Staff told us they had not attended training for caring for patients living with dementia. There was however training for supporting patients living with learning disabilities.

In 2015 the dementia specialist nurse was available to support ED staff if required and advised they planned to develop dementia link nurse roles for staff in ED. Patients attending with mental health problems were cared for by the ED team who could ask for specialist psychiatric nurse advice. The trust was implementing additional support to work more closely with the ED. This was in response to patients with mental health needs who were waiting long periods in the ED or admission unit for assessment. Patients in severe mental health crisis who needed a place of safety were transferred to the nearest dedicated unit in Fulbourn, Cambridgeshire. The ED and psychiatric team of the hospital, and police when appropriate, provided support until patients were transferred.

In 2014 the emergency department provided a service to a diverse population. We saw that there was signage in the department and patient information leaflets had been written in a number of different languages.

In 2015 we observed staff interacting with patients. Staff gave easily understandable explanation to support patients in making informed choices. We saw that staff asked for consent before undertaking patient's treatments. We asked staff about assessing mental capacity when required. Staff explained they knew when this would be recorded and the appropriate documentation from the computer system to be used.

Urgent and emergency services

Leaving Hospital

The department failed to meet the target for unplanned re-attendance in the year to date being at least 1% above the national average in this category and year to date around 6.2% This meant that a higher than expected number of patients re-attended the emergency department within a given time frame, having previously been discharged.

The emergency department can access the GP notes through a clinical records viewer system. GP's are able to see patient results through an IT system known as ICE. We were told that a handwritten letter would be sent out to the GP if needed (if the patient required an urgent appointment, for example).

Learning from experiences, concerns and complaints

Patients attending the emergency department had a range of routes they could follow to provide feedback about the care and treatment they received. All patients had the opportunity to complete the Friends and Family test; this asks questions about the level of satisfaction with the hospital experience. The results for the A&E department was significantly above the national average scoring 62 as opposed to the national average of 56.

Patients could also make a formal complaint or contact the Patient Advice and Liaison Service (PALS) to provide feedback or for help in making a complaint. We were told that complaints were responded to according to trust policy. The complaints-handling process was devolved to individual directorates for investigation of the complaint; this had caused a delay in response times. The matron for the emergency department maintained a log of all complaints and used this information to monitor trends and learn lessons. The department received between two and 10 complaints per month on average. The matron showed us an example of a complaint that had been responded to. We were also told that, depending on the severity of the complaint, the matron and/or lead nurse for the emergency department met with the complainant to discuss and address their concerns directly. One patient we spoke with told us that they had previously made a complaint and that they were satisfied with how this had been handled: a meeting with trust staff had been arranged, which they were pleased about.

Are urgent and emergency services well-led?

Good

In 2014 we found the emergency department to be well led. In 2015 we found then department continued to be led by senior staff with a clear vision for the service and evidence of meeting milestones in the strategy such as the recruitment of consultant staff. There were appropriate governance arrangements in place with regular audits and learning from incidents.

Staff spoke positively of senior leadership and told us they felt able to raise concerns and that they would be listened to. There was clear evidence of working with external stakeholders such as the CCG and other trusts to improve the quality of care and the flow through urgent care services. The identification of new pathways through the directorate, such as the newly opened medical admissions unit, demonstrated a commitment to improving services.

Vision, strategy and risks

In 2014 staff understood the trusts vision and values and were able to demonstrate these in their work. A risk register was maintained for the Emergency Department. High and significant risks fed into the directorate and trust-wide risk registers. Each risk had an owner as well as an executive lead. Risks were rated, monitored and reassessed each month, and each risk was linked to an action card. We saw that some of the high or significant risks for the emergency department had been reviewed in line with the date agreed; however, some of the medicine actions within the same document were overdue.

Quality, performance and problems

In 2014 there was a clear structure for reporting lines at operational level within each of the units in the emergency department. We were told that the shift was always led by a band 7 nurse. Concerns could be reported to the lead nurse for the Emergency Department and out of hours there was a site manager who could be contacted in the event of an emergency. In such cases, the duty manager would be called. A clear committee structure was in place, with each member having responsibilities relevant to their teams.

Urgent and emergency services

In 2014 staff were aware of the department's key targets, including the four-hour target, and told us about the importance of meeting this target, but that patient care must always come first. However audits were not being undertaken as planned, as guidance was awaited, and this meant that the department could not benchmark performance against others. We saw that performance against target was monitored using a balanced scorecard. The scorecard specified targets and achievement against target each month or quarter. Achievement against target was colour-coded using red, amber and green. Services for children had been reviewed and plans were in place to meet the national guidance available. However at the time of our inspection these were not in place and the services for children and young people were limited.

In 2015 we found there were established systems to ensure good clinical governance and monitor performance. There were a number of audits carried out and we saw from minutes that mortality and morbidity meetings were regularly held. We saw that actions following from incidents, audits and other checks were followed up by the ED team and directorate board overseeing the service. This included ensuring clear audit plans, checking rates of attendance at mandatory training and staff sickness and retention.

Leadership and culture

In 2014 the department had a clearly defined structure and patient pathway. Staff told us that they felt well supported and were able to share concerns as they arose, through either whistleblowing or incident reporting. We were told that there were fast-track pathways for some specialties. We reviewed a sample of patient notes and found that these had been followed. We were told by staff that inter-department working for obtaining a specialist opinion or a bed on a ward varied between the different wards and specialties. Data relating to reasons for breaching the four-hour target indicated that a significant percentage of breaches were due to lack of availability of beds as well as to waiting for specialist opinions.

The Emergency Department supported its staff following serious incidents and we were told that, where necessary, debrief sessions would be held with staff; we were told about a recent example of this. Lessons learned from incidents and complaints were discussed with the individuals concerned as well as being shared at the staff team briefing. Team briefings took place and could be used to encourage and support staff and to boost morale when needed. We were told that patient accolades were also monitored and shared with staff. Staff had access to formal counselling via occupational health if required.

In 2015 we found there was effective leadership of the ED. There had been a change of manager and a matron for the ED. There were clear messages to staff about the expectations of the managers and support available to staff. Medical leadership was effective with consistent support for middle grade and junior staff by the clinical lead and team of consultants. There had been long term plans to increase consultant numbers which had been achieved. This was in response to the growing patient attendance to ED and the need to provide specialist urgent medical care.

In 2015 staff said they felt the Trust Chief Executive visited the department and was aware of issues in the ED.

Patient experiences and staff involvement and engagement

In 2014 the staff we spoke with told us that they felt supported and listened to by management and that their line manager, the lead nurse and matron were all very approachable. The trust had a policy called 'Raising concerns in a safe environment'; the staff we spoke with told us they were aware of the policy and felt confident in reporting concerns if they needed to. One member of staff told us how they had shared concerns in the past and that they were happy with how the information they had shared had been managed.

Patient feedback was sourced through a variety of mechanisms and the Emergency Department used the feedback to make changes. We were told that pain management on arrival into the department had featured as a concern for a small number of patients; as a result, the department had incorporated a medicines cabinet in the Emergency Department reception area. A qualified nurse worked on reception, which meant that patients treated for minor injuries could access pain relief promptly on arrival. The noticeboard within the Emergency Department displayed details about recent performance against key indicators as well as details of recent action taken following patient feedback.

In 2015 staff told us they felt they were able to raise concerns and issues and there was good communication

about changes. Staff told us the new manager and matron were visible and supportive. Senior staff told us they felt they were working in a trust that supported them to make changes to improve the service.

Learning, improvement, innovation and sustainability

In 2014 we saw that staff were given positive encouragement by management within the department, which promoted good team working. The number of accolades each month was recorded and also shared with staff individually. Staff briefings were also used as a forum to congratulate staff on achievements. We were shown an example of this: the December meeting recorded in the action notes a 'thank you' to everyone for achieving the four-hour target.

In 2015 we saw the department consultants and lead managers had worked with partners in the health economy to manage patient flow issues. The Trust had worked with ambulance services and with clinical commissioning groups on improving ambulance turnaround times and reducing delayed transfers of care from the hospital. The changes supported the achievement of the four hour target at the time of our visit.

In 2015, within the ED and Medical Admission Unit there were increased therapy staff support to improve the assessment and preparation of patients for discharge. Any delays identified at board rounds were escalated immediately to reduce diagnostic delays and promote flow of patients through ED, the admission unit and to appropriate ward areas.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Peterborough City Hospital's medical care service has 11 wards catering for the specialisms of cardiology, renal care, gastroenterology, general medicine, stroke care, respiratory care and care of the elderly and an isolation ward. Linked to the hospital's accident and emergency service (A&E) is the emergency short-stay (ESS) ward, with 49 beds provided, and an ambulatory care unit (ACU), which has the capacity for up to 30 patients seen as day cases. The hospital had introduced an emergency medical unit (EMU) last autumn within the A&E department; this has the potential capacity of using up to 16 of the A&E or ESS beds when the EMU is operating effectively.

In 2015 the hospital opened the medical admission unit (MAU), in place of the ESS and EMU, with 49 beds receiving patients from A&E and direct from GPs for assessment. The ambulatory care unit (ACU) had increased capacity from 30 patients to 50 patients daily to reduce the need for admission.

Overall, the hospital's medical care service has 307 beds. The bed occupancy for general and acute departments (including the medical care service) for the period from July to September 2013 was 90.7% across the 561 beds available. This is above the England average of 86.4%, indicating a higher than average demand on the beds available.

In 2014 the cardiology care service saw 3,600 people as inpatients in the past year and also had 1,200 people seen as day cases in the same period. The cardiology service also provides diagnostic angiography, simple permanent pacing, transesophageal echo assessments and a full range of cardiac investigations. Rapid-access chest pain and heart failure clinics with one-stop diagnostics are held weekly.

In 2014 the stroke care ward had 580 admissions in the past year. The stroke service provides a thrombolysis service using an in-house staff team during weekdays and a telemedicine service at night and weekends. High-risk transient ischaemic attack (TIA) patients are assessed within 24 hours. There is also a one-stop neurovascular clinic for low-risk TIA patients. Stroke follow-up clinics are provided with some nurse-led follow-up.

Care for older people is provided by two 29-bedded wards with one specialising in Parkinson's disease and the other in delirium/dementia. Outpatient clinics for falls, Parkinson's disease and general medicine are also provided.

During our inspection in 2014 we visited 10 out of the 11 wards in the medical care service and spoke with 24 patients, 48 staff and four people visiting relatives. We also looked at the records of eight people.

In 2015 we visited nine wards and spoke with 39 staff, 15 patients and seven relatives. We were supported by one specialist advisor during this inspection. We also observed care and treatment and examined the records of 21 people using this service.

Medical care (including older people's care)

Summary of findings

In 2014 we undertook a comprehensive inspection and found that overall medical care services at this hospital required improvement. During that inspection we found that, while staff had effective handovers and access to the appropriate guidance available to care for people safely, a large proportion (40.7%) of safety incidents reported were from the medical care specialties. These incidents related to patient falls, pressure area care and infection control.

In 2014 Some staff and patients told us that they felt staffing levels were unsafe at night and at weekends and we saw that there were significant nursing vacancies in some ward areas. However at our unannounced evening visit on 10 March 2014 we found there to be sufficient staffing on the three medical wards visited. We found that targets set nationally and locally for patients were not always met. This included the transfer of patients to specific wards and effective discharge planning. The respiratory ward was not carrying out one national clinical audit (BTS emergency oxygen). National audits from the previous year were removed from the list for 2013/14. The stroke unit was under-resourced at consultant level. The cardiac unit did not have cardiologist cover during the weekend.

In 2014 the interactions we observed between staff and patients were all positive and supportive and the staff responded to patients' needs, including for emotional support. Patients and visitors told us that staff were caring and kind at all times. However, we did see instances when staff were too busy to respond appropriately to calls for assistance and the call bell reports showed that over 20% of call bells were not responded to within five minutes. Ward managers monitored complaints and incidents and looked at themes; we saw evidence that actions had been put in place as required to address the areas of concern.

In 2014 governance arrangements were in place across the medical care service but not all clinical audits as recommend by the National Institute for Health and Care Excellence (NICE) were being carried out across all wards. Each ward followed trust wide processes for monitoring incidents and accidents and significant areas of risk were placed on the hospital's risk register.

Junior staff told us that there was a lack of effective change management and leadership and that key messages were not effectively cascaded down the organisation. .

In 2015 when we returned to this service to follow up on improvements we found that there had been significant effort to address falls management and pressure care. However incident numbers remained significantly high with an emphasis on individual feedback. Further improvements were required to ensure learning was widespread to reduce risks to patient safety. Staffing was improved, with staff recruited from overseas; however there remained a reliance on agency and bank staff. Records and documentation were poor, with records lacking in detail and not updated consistently. Temperature recordings in areas where medicines were stored were not completed appropriately.

In 2015 in order to deal with effective discharge planning the trust had implemented discharge trackers and opened a medical assessment unit to improve patient flow throughout the hospital. We found that timely admission to the stroke unit remained an issue as did consultant staffing and auditing within the respiratory service. The majority of staff treated patients with compassion and care however this was not consistent and there were some incidences of poor interactions which were brought to the attention of ward managers. Data from Jan-March 2015 showed response to call bells under 5 minutes as averaging over 80%.

With the exception of a few areas, staff felt communication was good and that there was a positive move from the trust to be more open and core values were beginning to be embedded.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

In 2015 safety in the medical service remains as requires improvement because the trust has made insufficient progress since our last inspection to ensure that patients are protected from potential harm or abuse. In 2015 we found that medicines were not always stored correctly due to inconsistencies in monitoring fridge temperatures. We saw that infection control practices were not always followed and gel dispensers were found to be empty or not working on a number of wards including A wards 8, 9 and 10. The C. Diff target had been missed with a total of 41 cases for 2014/15 against a target of 31. Nursing records were not always well completed with gaps in assessments and observations were not always recorded when they were scheduled. Staff told us that they were concerned that they could not cope with the acuity of some patients, however the trust had completed the safer nurse staffing tool and levels of staffing were in line with the outcome of this audit tool.

Incident reporting remained high and this was seen as an indicator of a positive reporting culture. The trust had previously redefined the reporting of falls without harm and this had caused a rise in the number reported. There had been a programme to reduce falls and pressure ulcers though rates remained consistent on data reviewed. There had been a drive for nurse recruitment across the medical directorate and we found that staffing was being maintained on wards with use of agency and bank nurses. Staff told us they were supporting large numbers of new and overseas nurses.

Safety and performance

Our inspection findings in 2014 were that for the period from December 2012 to November 2013, medical care specialties had the highest number of patient incidents: 123 incidents out of a total of 302 reported across the hospital (40.7%). These incidents related to patient falls, acquisition of pressure areas within 72 hours of admission and infection control issues. Pressure ulcers within 72 hours of admission are reported by the Trust but attributed to the community. We found a culture of reporting incidents across the medical wards.

Learning and improvement

In 2014 we found that the hospital had protocols in place to monitor and assess risks to patients in the key areas of pressure ulcer care, catheter-acquired urinary tract infections, infectious diseases and falls with harm. We saw appropriate documentation on patients' files regarding the above and effective care plans in place.

In 2014 the hospital recategorised the harm from falls to include all falls which resulted in injury in July 2013. This has led to a spike in reporting which shows the hospital as being above the national average. Whilst the trend is downwards it remains above the national average. We heard that there had been increase focus on fall prevention and saw that aids were in place to reduce the risk of harm from falls. A large proportion, over 50 % of rooms were single rooms which presented challenges for nursing staff to reduce the risk of falls. However the hospital raised the awareness of steps staff could undertake to reduce the risk of falls and this was clearly working on the medical wards. We saw effective assessments of risks for venous thromboembolism on patients' files; 94.3% of these assessments had been completed against the target of 95%. Staff we spoke to were aware of the key risk areas for the hospital.

In 2015 we found that incident reporting remained high. Skin integrity and falls prevention was a focus throughout the trust but remained an area for improvement. The rate of patient falls, pressure ulcers and catheter related urinary tract infections (UTIs) between December 2013 and December 2014 remained consistent with only slight fluctuations month on month. The number of new pressure ulcers, developing after 72 hours of admission, had increased in January – March 2015 to 2%. The trust had recruited a Falls and Fractures Prevention Specialist Nurse in April 2014 to lead on activities to reduce the number of falls. There were tissue viability link nurses identified in ward areas to promote care and provide training for staff. A scrutiny panel met monthly to discuss all serious incidents and review action plans.

In 2015 B6 was identified as a ward with a high number of falls (100 were reported between Jan - Dec 2014). Information regarding falls was provided to staff on a falls prevention notice board which included details such as the number of falls on the ward and identified medication that increased the propensity to falls. Staff told us that that were getting better at identifying the risks but now needed to

make improvements with understanding what they need to do to mitigate risks. Several staff stated that issues would be investigated and raised with individuals concerned. The general feedback was that the focus was on individual learning and feedback. The wider opportunity to learn from incidents was not evident across many of the medical areas.

Systems, processes and practices

In 2014 we saw effective handovers taking place to ensure that staff had appropriate guidance to manage the care of patients. We saw that incidents were recorded and reported effectively and that action plans to reduce risks were in place. There were effective infection control protocols in place. Staff told us that night staff cover was a concern at times and that sometimes they felt that staffing levels were unsafe. However at our unannounced visit on 10 March 2014 we found that there was appropriate staffing in the evening on the three wards we visited. Patients and visitors told us that the wards seemed short-staffed, especially at the weekends. Some wards had significant nurse vacancies and some staff reported that a high staff turnover affected staffing cover. Safeguarding training had been provided to staff and they were able to tell us of the procedures for reporting concerns. Medication systems were robust and secure, apart from one instance when there was no capacity assessment or care plan in place for self-administering of medication.

In 2015 we found that on the majority of medical wards a full multidisciplinary team handover took place twice a day at the white boards to enable all staff to communicate concerns and changes in a patient's condition. On B14 the handover occurred however staff referred directly to the electronic (ETrack) system. This was updated throughout the day and staff could print off the details for the patients they were looking after. However this meant that not all paper documentation was up to date for the patients as the reliance was on the electronic system. Having two systems could increase the risk to patient safety as it was not always clear what the current status of a patients care was.

In 2015 nursing staffing numbers, both predicted and actual were displayed on each ward. Staffing was divided into three teams on each ward with a sister or deputy co-ordinating. Ward managers were supernumerary and in addition to staff numbers when working. During our inspection there were sufficient staff numbers with typically one trained nurse and one health care assistant to eight patients. There was a trust wide recruitment drive underway and nurses were being recruited from overseas. There were vacancies for a variety of staff grades on several of the medical wards which were being advertised. To cover gaps agency and bank staff were in use in all areas. Staff told us they were supporting a lot of new starters and overseas nurses who needed support. Patients said that their impression was that there was sufficient staffing during the day but this varied at nights and weekends. However, rota's indicated that actual staffing numbers were being maintained to those planned for out of hours.

In 2015 temperature recording on drug fridges and areas where medications were stored was inconsistent across the medical service. On A8 ward records showed that fridge temperatures were not always recorded each day between January and April 2015. Staff on the ward could not confirm if temperatures had been checked during this period. On four wards the fridges were noted to have passed the date for the next service to be undertaken which was the end of April 2015 and no actions had been taken to organise the next service. This meant there were insufficient systems to ensure that medicines were stored at temperatures that kept them in optimum condition. During this inspection we found that infection control practices were not always consistent and required improvement. On ward A8 a member of staff was observed entering multiple patient rooms with prepared intravenous preparations. The member of staff was not wearing the appropriate personal protective equipment (PPE). This was brought to the attention of the deputy charge nurse at the time.

In 2015 the trust had failed to reduce the number of cases of C. difficile(C Diff) to 31 or fewer, with 41 cases occurring in 2014/15. On B6 staff informed us that there had been several outbreaks of C Difficile every two months. Ward B6 had outbreaks of diarrhoea and vomiting in February, August and November 2014 and January 2015.The trust had initiated a bed cleaning programme and the ward was given a deep clean in November 2014 and had not had an outbreak since. All staff completed training following the last outbreak and were aware of reporting actions and as soon as a patient was experiencing symptoms they were put into a side room for isolation.

Gel dispensers were situated at regular intervals throughout the wards. However these were battery operated units and found to be faulty on a number of

wards including A8, A9 and 10. On the second day of our inspection we saw that notices had been affixed indicating they were not working and that additional gel dispensers were now in place. It was noted as a recommendation following an unannounced infection prevention and control audit on 9 April that a system for checking of gel dispensers regularly and replacing batteries should be developed.

Monitoring safety and responding to risk

In 2014 we found that staff were not using a low rise bed for one patient who had had a fall; such a bed had been used on previous wards as the patient had a history of falls. When we spoke to the relatives of the patient, they were concerned about why the low riser bed was not being used. The ward responded by providing a low rise bed but we found on the second day of the inspection that the falls risk assessment and care plan had not been updated to reflect the fall and the risks to the patient.

In 2014 we found one person had not had their fluid and food intake charts and positional change charts updated for over four hours; the staff told us they had been very busy. This could have had an impact on the care and treatment of the patient as their records did not reflect their current status. Staff showed appropriate understanding of the deprivation of liberty safeguards and in caring for people with reduced capacity to consent.

During our inspection in 2015 our findings were that there was specialised equipment available and in use, for example pressure relieving pads on chairs, repose boots, pressure relieving mattresses and low rise beds for patients at risk of falls. The en- suite bathrooms were spacious and well equipped with mobility aids. Patient said that grab bars were helpfully positioned.

In 2015 clarity and detailed documentation was lacking across all medical wards. For example 21 nursing notes were reviewed and there were gaps noted with risk assessment, skin integrity checks, catheter care bundle and clinical observations were not always recorded when scheduled. One patient with a NEWS (national early warning score) of three required monitoring 4-6 hourly but had a ten hour gap where observations had not been taken. Care planning lacked detail for example "needs assistance with washing and dressing" was written but no further specific details. A mobility care plan stated "due to illness patient is dizzy" and a nutrition care plan stated "not tolerating much milk".

In one set of nursing notes a patient had a DNACPR (do not attempt cardio pulmonary resuscitation) in place from April 2015. It had been documented that the relatives had not been in attendance though there was no evidence that the patient lacked capacity to make decisions. Records indicated that staff had agreed to discuss this with the patients family but that it had not been done. We brought this to the ward managers' attention, who spoke with the consultant and medical team. It was arranged that they would speak with the relative regarding this the following day.

Anticipation and planning

In 2014 staff told us that each ward had an escalation procedure in place for staffing levels but that some wards were frequently on 'red' status as bank or agency staff were not always available. Staff could be brought in from other areas but staff told us that at times they were under pressure due to the lack of appropriate staffing levels.

In 2015 Staff informed us that they felt that there was not always enough staff depending on the acuity of the patients but were able to explain the escalation process that would be undertaken. On several wards there were additional staff allocated where a patient required one to one care. These additional staff were often requested via the hospital bank or agency. Additional staff employed to care for patients on a one to one basis were in addition to the usual staff numbers on the shift.

Are medical care services effective?

Requires improvement

The effectiveness of the medical service remains as requires improvement because the trust has made insufficient progress since our last inspection to ensure that patients receive an effective service by the monitoring of quality and provision of a service in line with national guidance. In 2015 The stroke unit was continuing to miss the target of patients admitted to the stroke unit within 4 hours at 51% against a target of 80%. The numbers of audits in respiratory medicine had improved since 2014 with 3 of 5 audits continuing at the time of our inspection. An additional consultant had been appointed to the stroke

service though there were concerns at the amount of cardiology cover out of hours. Patients who required support with nutrition and hydration did not always receive this help or adequate support.

There had been progress in the stroke service with a new stroke pathway in line with national guidance and a consultant led telemedicine service out of hours. A stroke coordinator was in post providing a 24 hour seven day service. Generally there was effective MDT working including managing discharges, however we saw two occasions when this did not occur.

Using evidence-based guidance

In 2014 we found that the stroke ward's pathway for care and treatment were not in line with national guidance as occupational therapy and physiotherapy input did not meet national guidelines for the level of support patients required. Due to capacity and demand issues, patients were also frequently placed on other wards; however, they did receive medical reviews as required. The trust participated in the Myocardial Ischaemia National Audit Project (MINAP) which showed that the trust was performing in line with other trusts apart from the number of referrals to angiography which was lower than expected. The trust are reviewing this issue with the cardiologists. The trust currently has no mortality outliers.

In 2015 there had been some progress made within stroke services but further improvement was required in relation to the four hour admission target and number of outlying patients. Ward B11 was a 28 bedded hyper acute stroke ward with one trolley bed allocated for urgent admissions. 7 additional beds could be used on ward B14 if required. These patients remained under the care of the stroke clinicians. There was a stroke pathway in place which was in line with national guidance using a recognised tool for patient assessment. There was a consultant telemedicine service out of hours.

In 2015 a stroke coordinator role had been developed and there was a team of six staff in place providing this service 24 hour seven day service. The stroke co-ordinator assessed patients, liaised with the wider team such as the emergency department, wards and other staff groups and helped to arrange bed availability.

In 2015 NICE guidelines (national institute of clinical excellence) recommend that all patients with non-ST-segment-elevation myocardial infarction (NSTEMI) or unstable angina are offered coronary angiography within 72 hours of first admission to hospital. Between January and April 2015 the Trust achieved an average of 74% for patient receiving angiogram within 72 hours. In order to address the low referrals to angiography, an internal audit had been carried out and it was found that all high risk patients were transferred to the nearby specialist trust for treatment. It was reported by a member of staff that this would account for the lower figures.

Performance, monitoring and improvement of outcomes

In 2014 we found that only 65% of patients were transferred to the stroke ward within four hours. One patient and relative we spoke to said it had taken eight hours to be admitted to the stroke unit as there was a lack of available beds. Data to monitor the number of patients admitted to a stroke unit was seen to be achieving the targets set. In December the target was 80% and the trust achieved 89.4% of patients spending 90% of their time on a stroke unit.

In 2014 the respiratory unit was not carrying out clinical audits as per NICE guidelines for adult asthma, adult bronchiectasis, adult community-acquired pneumonia, emergency use of oxygen, and non-invasive ventilation. Staff were not able to tell us why these audits were not being carried out. The trust confirmed that national audits from the previous year were removed from the list for 2013/14. Other wards were carrying out effective clinical audits.

In 2015 we found that timely admission to the stroke unit remained an issue. Data for admission within the four hour target for the last year indicated that performance varied between 49% and 62.5%; in April 2015 the trust achieved 51.5%. The low level of performance was attributed to capacity issues. The target of 80% of patients spending 90% of stay on a stroke unit was being met and 83% was achieved in April 2015. Patients not admitted to the stroke unit had a daily review by a stroke consultant or registrar, during the week, although this was varied at the weekends.

In 2015 some audits had been undertaken within the respiratory service however this remained an area for improvement due to the minimal number of audits completed and lack of responsive actions implemented to improve patient care when identified. For example the respiratory service had planned to participate in five national audits in 2014/15. However, two of these audits had been abandoned and three were either on-going or still required outcomes as to compliance and areas for

improvement. Two local audits had also been actioned: one of which was on-going and another with the outcome of non-compliant in relation to DNAR decisions being carried forward into the community. This meant that the service could still not demonstrate it was meeting NICE guidelines or had made suitable improvement based on regular audit outcomes. There was an action plan in place to increase the number of audits undertaken to eight in 2016/17.

Staff, equipment and facilities

In 2014 we found that the stroke ward was not meeting national guidance as there were only two consultants in post, as opposed to three. Also, for the cardiac wards, there was a lack of dedicated consultant cover at the weekends. There was an effective staff delegation of duties in place for each shift and wards used a RAG (red, amber, green) rating system for staffing cover emergencies. We found that access to CT scans for stroke patients was very efficient. Staff on the medical wards told us that there was no consistent ownership of the four-hour transfer targets for patients from the emergency department, and that this had an impact on whether patients were appropriately cared for on the correct wards. We were told that one of the factors causing delays in transferring patients to appropriate wards was the cleaning of beds, which should take 30 minutes but frequently took an hour and a half due to the inclusion of an en suite bathroom.

In 2015 consultant staffing on the stroke ward (B11) had been increased to three. Funding had been secured for a third substantive post and recruitment was underway however there is a national shortage of stroke consultants which had resulted in a locum currently filling the third position. Dedicated consultant cover at weekends for cardiology remained an issue. There were four consultant cardiologists in post, (3.6 whole time equivalent), which was insufficient to cover out of hours. These consultants were also still required to participate in the general medical rota; therefore there was not a separate cardiologist on call at weekends and out of hours. There was a full time locum in post to cover between six and eight cardiac clinics a week which had a financial implication for the Trust.

In 2015 there were acute coronary syndrome specialist nurses in the trust however their service had recently reduced from six days to five days. The medical admissions unit (MAU) was opened on the 7th May 2015. Staff were positive and hopeful that this would address patient flow and reduce patient transfers as patients would be admitted to the most appropriate ward in the first instance.

Nutrition and hydration

in 2015 the provision of nutrition and hydration in medicine required improvement. Staff informed us that it was not always possible to assist all patients that required help with eating and drinking in a timely manner. Reasons were not enough staff at times when the ward had a high number of patients that needed help. There were some volunteers on wards however they had to be allocated appropriate patients as some could not assist those patients with a higher degree of swallowing difficulties. One patient informed us that they had been in the toilet when meals were delivered and no meal had been left for them by the domestic staff. The patient received a meal only once they had requested it. This could mean that patients who were less able to communicate may be at risk of missing meals if they were not present at the time of delivery.

In 2015 one patient on B11 was nil by mouth and diabetic. They did have an intravenous drip however the bag had finished, ahead of schedule. It was noted that they had previously received medication and nutrition via a nasogastric (NG) tube. This had been removed on the 13th May, attempted to be repositioned on the 15th and 16th with no success and there had been no further documentation regarding this since. This was brought to the attention of the ward manager, and we were informed that the patient was due for review that day, 18th May, by the team. We could not be assured that any nutrition or medication had been administered for the previous five days and there was a lack of urgency in the response from staff to the concern we raised. We brought this to the attention of the Chief Nurse and saw that these concerns were addressed. We followed this up the following day and found the patient had the nasogastric tube re-sited and was receiving nutrition.

Multidisciplinary working and support

In 2014 we were told by staff that multidisciplinary working on the respiratory unit was not effective. The stroke ward had an effective system for multidisciplinary meetings and shared learning.

In 2015 our findings were that physiotherapy provided a service Monday to Friday and were on call at weekends and out of hours. There were designated physiotherapists and

occupational therapists on each medical ward which provided consistency for patients. Staff handover took place twice a day with an MDT staff whiteboard meeting. New 'discharge tracker' posts had been created with responsibility for identifying and resolving any delays in discharge. Discharge trackers liaised with doctors, pharmacists and nursing staff. This group said the role was welcomed and communication between all parties was good.

In 2015 we observed one patient being assisted by a physiotherapist and staff nurse on ward A8. Following assistance the physiotherapist spent some time chastising the staff nurse in full view of the three patients within that bay. The staff nurse was clearly upset. This behaviour was reported to the senior nurse on duty immediately as unprofessional. On another ward two staff were overhead holding a discussion regarding another patient's condition whilst making the bed of another patient which was inappropriate.

Are medical care services caring?

Requires improvement

In 2014 we found that caring required improvement in the medical directorate as call bells were not always responded to in a timely manner. In 2015 the majority of staff demonstrated a caring attitude when providing care and treatment. However, we saw a number of incidents were appropriate help and support was not provided to patients. These included staff who did not communicate with patients and other staff who did not give patients assistance when they were obviously struggling. Relatives and carers we spoke with told us that they were not always given enough information about the plans for care. Therefore this area was rated as requires improvement as sufficient progress has not been made to ensure that all patients are cared for in a supporting environment.

The Friends and Family Test for the medical wards was positive with all wards reporting greater than 85% of patients recommending the ward and a number of wards scoring consistently at 100%.

Compassion, dignity and empathy

Our findings during the inspection in 2014 were that in the December 2013 NHS Family and Friends Test, ward A10 (gastroenterology) scored a 50 satisfaction rate compared with the trust average of 69. Ward B14 scored 39 and ward A9 scored 65. Both these wards were care of the elderly wards. On one ward, we observed one patient in distress calling out for over four minutes. Staff were within earshot but did not respond quickly to reassure the patient.

In 2014 records showed call bell response times provided to us, we saw that for January 2014, five of the medical wards had significant delays in call bell response times, with all five having over 20% of calls not responded to within five minutes, which was the hospital's expected response time. Some patients we spoke to confirmed that they were kept waiting, especially at peak times in the day, for example during medication rounds.

During our inspection in 2015 we found the majority of staff treated patients with compassion and care. However this was not consistent across all areas. The Friends and Family Test for the medical wards was positive with all wards reporting greater than 85% of patients recommending the ward and a number of wards scoring consistently at 100%. On wards A8 and B11 staff were observe to have minimal interaction with patients. For example, during observation in one four bedded bay, a member of staff came in and cleaned the area but this was done in complete silence, they did not introduce themselves or say hello and had no interaction at all with the patients in that area. There was a green light at the entrance to each room and bay area which was used to indicate when a member of staff was present in the bay or side room. We observed its use in practice but there were at least three occasions when the green presence light was left on when staff had left the room.

In 2015 there was a lack of awareness at times for patients needing additional assistance. In another four bedded bay, cakes and snacks were given out however the cakes were individually wrapped and patients struggled to open the wrappers and no assistance was offered by staff. On two occasions there were patients struggling to eat for over five minutes. One patient was at risk of harm from burning themselves as they were attempting to use their hands and had not received assistance. There were staff in the area but they were involved with other patients and we observed this patient being ignored. In both situations we brought this to the attention of the team and assistance was provided.

Medical care (including older people's care)

In 2015 one relative informed us that their mother had reported to have experienced rough handling from two members of staff during the night at the weekend. The patient had also made a request for a fresh incontinence pad however this was not provided and one member of staff was overheard by the patient to say "forget it", in terms of providing her with the new pad. This relative also informed us that their mother had not been dressed by 2pm on the Saturday before our inspection. Staff had informed them that they didn't have time to wash their mother and that they could not find her clothes, despite them being in the patient's locker. The relative had not brought this to the attention of staff as they had been concerned that their mother may be vulnerable the following evening. We brought this to the attention of the ward manager whilst maintaining the anonymity of the individuals concerned.

Involvement in care and decision making

In 2014 patients we spoke to told us that they were involved in their care planning and were kept informed of what was happening. We saw from patient records that consent forms were signed and in place. We saw that there were effective procedures in place for assessing people's capacity and that patient' representatives were involved in decision making if the patient lacked capacity.

Trust and communication

In 2014 most people told us that there was good communication with the staff and that they were kept informed of progress in treatment plans. However, two relatives said they found it difficult to speak to staff at times as staff members were very busy. Patients were complimentary about staff and appreciated the care and support they received.

In 2015 communication with relatives was varied. Some relatives stated they had been kept informed whilst others said that they had to ask for information before it was forthcoming. Some themes identified by relatives were that there was a lack of information about their relatives' condition, that it was difficult to find out about times of treatments and there were delays in diagnosis. We were told by a member of staff that following a patient fall that resulted in injury, the trust process was that the family would be contacted by the falls nurse lead and informed of the incident. The investigation report into the falls incident would be shared with the family and a meeting arranged to enable the family to ask any questions.

Emotional support

In 2014 the interactions we observed between staff and patients were all positive and supportive and that staff responded to patients' needs, including for emotional support. Patients and visitors told us that staff were caring and kind at all times. Patients on the stroke ward had appropriate access to a clinical psychologist.

Are medical care services responsive?

Good

In 2014 we found that medicine wards required improvement in relation to responsiveness. In 2015 we found the medical assessment unit had improved patient flow and reduced the number of medical outliers in other ward areas. The trust had improved their discharge processes and had recruited in to a 'discharge tracker' role that was facilitating discharge arrangements for inpatients and streamlining the discharge process however there was as yet no data to demonstrate the effectiveness of this system. Most recently available data showed that the medical directorate was meeting its referral to treatment time targets.

In 2014 we found that call bells were not always answered in a timely way. In 2015 we saw that there could still be delays in call bells being answered, in March 2015 over 50 call bells rang for longer than ten minutes out of the 6,800 calls. It is unusual to be able to and good practice that the trust is able to monitor call bell response times.

Meeting people's needs

In 2014 the capacity and demand issues in the emergency department impacted on the functioning of the ESS and ACU, which were used on a frequent basis for caring for the emergency department's patients. Staff told us there were pressures on the flow of patients from the emergency department and that frequently patients were not cared for on the correct wards. We observed on one ward that a call bell was not responded to within 20 minutes. The patient we spoke to later said that they had experienced delays in call bell response times. However trust data shows that on average the call bells across the trust were responded to within five minutes. We found that some of the medical wards had response rates in excess of five minutes.

Medical care (including older people's care)

In 2015 we found that the recently opened MAU had provided stability and process to patient flow. Patients could stay in MAU for up to 48 hours. At the time of our inspection there were 14 patients outlying in other specialty wards whereas prior to the MAU this number was around 60. Whilst the unit was in its infancy it was felt by staff that the benefit of the extended stay on MAU enabled patients to be transferred to the appropriate ward more effectively.

in 2015 there were monthly reports displayed on all wards regarding time taken for call bells to be answered with the target time being five minutes. In all areas visited the wards were achieving this target with results ranging between 1.5 and 2.5 minutes on average. On wards B11 and B6 nurses responded promptly to call bells with staff going to patients and assisting as required. However this was not always consistent in practice. Data from March 2015 showed that there had been over 6,800 call bells rung of which on 53 occasions responses had taken over ten minutes, four of which had been over twenty minutes. On four occasions during our inspection we observed responses to call bells that took in excess of nine minutes. On ward B14 one patient, who was clearly confused, was shouting out to the nurses repeatedly for help and it took six minutes for a member of the medical team to respond.

Vulnerable patients and capacity

In 2014 the numbers of patients admitted with dementia were increasing and the trust highlighted patients with this condition on their electronic patient system so that all staff were aware that these patients required extra care. Two wards has special areas for patients who had dementia to sit in and this memory area was used to orientate people to their current environment. The hospital had an equalities and diversity lead who advised and supported staff caring for vulnerable patients. On our unannounced visit we saw care provided to one patient who had dementia. The care provided was seen to be sensitive and compassionate.

Access to services

In 2014 due to pressures in the emergency department, and to bed availability, not all patients were transferred to appropriate medical wards within the hospital's timescale of four hours.

In 2015, in the two weeks of the MAU being opened, the Trust had achieved 95% of discharge from the ED within the four hour target which was an improvement from the 84% in January to March 2015 with the majority being transferred to an appropriate medical ward. For April 2015, the hospital was meeting its referral to treatment time targets for inpatient medicines specialties.

Leaving hospital

In 2014 staff told us that effective discharge planning was not always in place and one patient told us that they were ready for discharge on a Friday but, as there was no senior medical cover on Saturday or Sunday, they remained in hospital over the weekend. We were told that 6.76% of bed days were lost due to delayed discharges of care against the hospital target of 5%. This was due to the challenges the hospital faced in discharging patients to a number of different counties and the lack of service provision. We were also told that cardiac rehabilitation in the community was fragmented, impacting on discharge planning.

During our inspection in 2015 the Trust had started a "breaking cycle" initiative that reviewed discharge process, capacity and flow. Outcomes identified that work was required with community partners about the number of interim beds. Internally there were delays with radiology, particularly the review and reporting aspects. Wards were using breaking cycle forms to escalate issues of delayed discharge. Data comparing delayed bed days from March to February 2013/14 and 2014/15 showed an increase in the last twelve months of 35%. Discharge planning did not begin at admission across all areas. We reviewed 21 patient notes and the discharge information and planning section was not completed in 20 of the 21 records reviewed.

In 2015 the role of a discharge tracker had been implemented across the trust from September 2014 and there were now 17 in place across the wards. The aim of this role was to facilitate discharge, reduce delays and reduce administration tasks for nursing staff. The role encompassed problem solving, chasing blood test or investigation results, organising transport, communicating with next of kin and property organisation.

In 2015 there was a "traffic light magnet" system utilised on the white boards to indicate the status of patient tests and procedures which enabled staff to quickly review patient progress. Tasks that required action were marked as red. The added complications from dealing with six local authorities and six different health economies remained. There were 14 different referral forms in use which meant that the discharge trackers would need an in-depth knowledge of Peterborough geography to ensure the

correct authority were contacted dependent on the patient's postcode. This should be improved as from 1st June 2015 it was planned that there would be a single referral for discharge support assessment for the individual on E-track with the predicted date of discharge.Three discharge trackers said they felt there had been improvement and the role was achieving results however no numbers could be provided and it was unclear who was monitoring the effectiveness.

We were informed by a member of staff that the training that had been expected for the discharge tracker role had not yet been delivered. There had only been two induction days which identified the escalation process and individuals involved and a catch-up with discharge tracker leader to enable sharing of experience with other trackers. There had been no training regarding E Track and no ward induction.

In 2015 the delay in provision of medication for discharge (to take out medication) was highlighted on several occasions by staff and patients as an issue. Where possible the request for take home medications was made the day before planned discharge.

Learning from experiences, concerns and complaints

In 2014 and 2015 we saw that complaints and incidents were regularly discussed within team meetings and that individual learning from complaints had taken place. Ward managers monitored complaints and incidents and looked at themes. We saw evidence that actions had been put in place as required to address the areas of concern raised within complaints.

Are medical care services well-led?

Requires improvement

In 2014 we found that the services well led key question required improvement. In 2015 we found that issues that we had raised at our previous inspection had be yet to be embedded throughout the service. We found that the leadership on the wards was inconsistent and ownership of the issues was lacking in some areas. Therefore we have rated this aspect as requires improvement to ensure that patients experience a good service throughout this service. In 2015 we found that there was a clearer strategy within the directorate for managing patient flow and experience. Senior management and trust executives were very visible within the medical wards and there was a clear programme of relocating decision making and re empowering ward leaders. Ward managers were also being encouraged to work clinically to demonstrate local clinical leadership.

Most staff we spoke with were positive about the changes made and felt well supported by senior management and were able to raise their concerns. We were told that the trust was moving to a more open culture. There was a greater focus to identify training needs within the directorate than had been the case in 2014 though appraisal rates in some areas remained low.

Vision, strategy and risks

In 2014 the hospital had piloted an EMU in the autumn of 2013, but we found that this unit had not worked effectively for more than a few days at a time as there was an acute pressure for emergency department beds. The vision for the EMU was to provide effective care for patients to facilitate appropriate medical assessments, but staff told us of their frustration that there was not a coherent plan to ensure that this unit functioned effectively. Staff told us that physician support in the ACU was delayed at times. Staff told us that there appeared to be a lack of long-term planning and that issues were responded to reactively rather than proactively.

In 2015 there had been some improvements made in long term planning with the MAU opening to aid access and flow and a re-evaluation programme entitled 'Breaking the cycle' focussed on managing discharge arrangements. The MAU had only been opened two weeks prior to our inspection and the initial progress required sustaining and embedding. Senior staff on this unit had a number of plans to improve the service this department offered.

Governance arrangements

In both 2014 and 2015 we found that governance arrangements were in place across the medical care service but not all clinical audits as recommend by NICE were being carried out across all wards. Each ward maintained its own system for monitoring incidents and accidents and significant areas of risk were placed on the hospital's risk register. These included five thoracic audits and one on Parkinson's disease.

Risks we observed such as hand hygiene were known to the service prior to our 2014 inspection and continued to

be an issue which needed addressing. Similarly access to appropriate stroke services, response to call bells raimned issues which needed addressing. We found that the respiratory unit were not always undertaking appropriate audits an issue we raised in 2014.

Leadership and culture

In 2014 junior staff told us that there was a lack of effective change management and leadership and that key messages were not effectively cascaded down the organisation. Some staff expressed concern about the pressure to constantly work extra shifts and that this was not always recognised by managers. Two staff told us they had no faith in the hospital's whistleblowing procedures as concerns would not be addressed. We found that there was variable access to clinical supervision for nurses and that not all staff had had an annual appraisal. The departments appraisal rate was the lowest in the trust at 70%. Most staff did not receive regular supervision by their manager but they did say that there was effective informal support provided as required. We saw evidence that staff members' clinical competencies were assessed. We were told that regular team meetings took place on most wards.

In 2015 there was visibility from the senior management team and at executive level with visits to the ward areas. The duty manager undertook a walk around the wards every night. Communication was delivered through several routes such as team brief for lead nurses and senior managers, lunch time sessions for other staff members and information on the communication pages of the intranet. There was also support from the senior staff at ward level with ward managers working alongside staff clinically when required. All staff felt supported and comfortable to raise any concerns with their ward sisters, managers or matrons. Staff were confident that their concerns would be listened to. Staff were aware of the 'safe haven policy' on the intranet which provided guidance on whistleblowing.

In 2015 most staff felt communication was good and reasons were given as to why decisions had been made. Staff felt that there was a positive move from the trust to be more open and core values were beginning to be embedded. Staff appraisal remained poor. Data provided stated that only 57% of staff had an appraisal for the rolling 12 months from 01March 2014 to 31March 2015.

Senior staff in the directorate spoke highly of new directors and felt there had been a positive shift in the culture of the hospital and directorate. There was a greater emphasis on re empowering senior ward staff to make decisions about their own unit. There was a "tapping into your potential' programme which notified staff when training needed to be refreshed. The ward manager's assistant booked the training session well in advance and monitored that training attended. Staff felt that training was good but mentioned the impact on staffing "as always someone going off on training". However, information provided showed additional resource was available to wards to cover staff absence for training.

Patient experiences, staff involvement and engagement

In 2014 some staff said that they did not feel confident in being able to voice concerns. We saw that appropriate systems were in place to record patient experiences and these were shared with staff. Senior staff considered that they were involved in the strategic direction of the hospital but not all junior staff felt that they could contribute meaningfully to this process.

During our inspection in 2015 we were informed that there had been a restructure in the cardiac unit (CCU) which had resulted in one redundancy. It was felt that this had been a difficult period for the trust; staff felt that they had not been listened to which had resulted in a negative effect on staff morale. Staffing was a concern within cardiology, there were three band 6 vacancies and four band 5 vacancies. The band 5 positions had been appointed to from overseas but nurses had not yet taken up position.

Learning, improvement, innovation and sustainability

Management action plans were in place to highlight key areas for monitoring and review, and ward managers were able to inform us of the progress of these plans. However, not all junior staff were fully aware of the function of these plans.

Services for children and young people

Responsive	Good
Overall	Good

Information about the service

Services for children and young people at Peterborough City Hospital consist of one ward that has 28 beds plus two high dependency beds (Amazon), a paediatric assessment unit that has eight beds (Jungle) and a neonatal intensive care unit (NICU) that has two intensive care cots, four high dependency cots and 14 special care cots. There is also a separate children's and young people's outpatient department Rainforest).

During our inspection visit in 2014 we visited all departments within children's and young people's services. We talked with seven relatives, one patient and 26 staff, including nurses, healthcare assistants, consultants, doctors, support staff and senior managers. We observed care and treatment. Before our inspection, we reviewed performance information from, and about, the trust.

At our follow up visit in June 2015 we again visited all departments, spoke with 8 members of staff and reviewed records to ascertain what improvements had been made in the past year.

Summary of findings

In 2014 we found that children's and young people's services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.

Children's care and treatment followed best practice guidance and monthly audits were carried out regarding patient safety, patient experience and the environment. Parents we spoke with told us that they felt that their child received good-quality care and that they were informed about any treatment required.

We found that staff were responsive to people's individual needs; however, staff were unaware of the trusts guidance for staff on the ward areas when they needed to make a decision concerning same-sex accommodation. There was also limited support from the child and adolescent mental health services out of hours.

There was leadership at all levels within children's and young people's services and staff felt well supported well supported by their managers. A clinical governance frame was also in place.

In 2015 we returned to the service to assess whether or not improvements had been made in relation to the responsive domain where in 2014 the service was found to require improvement. This was specifically in relation adolescent service provision and the use of single sex accommodation. It was also identified that improvements were needed in relation to joint working with child and adolescent mental health services (CAMHS). We found that these improvements had been made and that the service had worked extremely hard to develop and progress projects and plans to meet the needs of the children and young people using this service.

Services for children and young people

Are services for children and young people responsive?

Good

In 2015 we returned to this service to assess whether or not improvements had been made in 2014 the service was found to require improvement. This was specifically in relation adolescent service provision and the use of single sex accommodation. It was also identified that improvements were needed in relation to joint working with child and adolescent mental health services (CAMHS). We found that these improvements had been made and that the service had worked extremely hard to develop and progress projects and plans to meet the needs of the children and young people using this service.

Meeting people's needs

The environment of children's and young people's services was visibly clean, bright and child-friendly. We noted that ward areas were designed to respect the patient's privacy and dignity.

During our 2014 inspection, we were informed that there was no specific adolescent ward area. Staff members informed us that patients between the ages of 16 and 18 would be admitted to an adult ward unless there was capacity on Amazon ward. Patients with a long-term medical condition, for example diabetes, would be accommodated on Amazon ward if necessary.

During that inspection we also found that guidance to support staff when they needed to make decisions concerning same-sex accommodation in the children's and young people's services was not accessible or understood by staff. However we were later advised that a policy did exist although staff could not provide this for us during the inspection. Staff we spoke with told us that decisions to move patients in the bays were made on an individual basis as and when required. However we could not be assured that decisions were made using a consistent approach or that the child's or young person's preference was sought in line with national guidance.

During our follow up inspection in May 2015 we found that the service had made significant improvements in relation to the provision of same sex accommodation and services for adolescents. The service had engaged adolescents in service development and improvement. We saw a number of patient feedback stories from adolescents giving their opinions on the service, one of these had even been presented to the trust board. There was a dedicated adolescent "den" in place on the ward which had been improved to contain age appropriate materials such as books, patient information, health promotion advice for teenagers and décor. During our inspection we saw this room being utilised by patients. Contact with youth advisors instead of play assistants was also being offered to adolescents and older children.

In 2015 staff we spoke with were much clearer on their responsibilities in offering patient choice when it came to same-sex accommodation. Bays were as far as practicable allocated as single sex bays. We heard that patient choice would be respected and that staff would provide explanation where this could not, for example, all single bays were in use or high risk patients needed to be cared for in a specific area meaning it may not be safe to allocate single sex bays. In order to demonstrate that patients had been offered a choice about where they were cared for, this included the choice of being on adult ward where appropriate, stickers had been placed in their care plans.

In addition we found that other work had been on-going with the aim of improving the service to meet children and young people's needs. For example, a new transition project had been agreed and was being supported by a CQUIN target for this year called "Ready Steady Go". This project aimed to build confidence and the understanding of children, younger people and their families' when transitioning into adult services.

All staff spoken with were consistent in their responses to demonstrated that the improvements seen were well embedded and sustainable. The service was supported by an extremely dedicated and passionate leadership team.

Access to services

Children could be referred to Jungle directly by their GP or by A&E. Once admitted to Jungle, the child would be reviewed by a paediatrician or registered children's nurse before being admitted to Amazon ward or being discharged home.

Interpretation services

Staff members in the Rainforest outpatients department explained to us how they accessed and used the

translation service. They told us that this would be initially flagged at the referral stage and a translator would be booked for the appointment; this would be either with an interpreter who attended the appointment or by phone.

Vulnerable patients and capacity

During our inspection in 2014, staff members confirmed that the child and adolescent mental health services (CAMHS) were not available out of hours. This service was provided by the local mental health trust. However, staff at Peterborough City Hospital had access to the crisis team if needed, although we were informed that the crisis team was at times hesitant about seeing a child or adolescent or about making a decision until the patient had been seen by CAMHS. We saw evidence that the CAMHS team supported and trained staff members in the ward areas and noted that a letter had been sent to the ward manager thanking them for a staff member's involvement in a young person's admission.

During our follow up inspection in May 2015 again, we found that the service had introduced a number of initiatives to improve the experience of patients who required CAMHS input. The team had worked hard to improve communication and relationships with the local mental health trust, we heard that whilst out of hours assistance was still not consistent this had improved. For example, we were told by five of the members of staff that we spoke with that the CAMHS team were now making daily contact, including at the weekends, to discuss patients requiring mental health support and to guide nursing staff where appropriate on interventions.

MDT meetings were also regularly taking place with the CAMHS team in attendance and we were told that hospital staff has now been provided with secure information sharing email addresses in order for mental health care plans to be shared for those children and younger people attending the service with known mental health conditions.

Leaving hospital

We were shown information that was provided to parents when their child was discharged from hospital. This included a business card with a direct telephone number for Amazon ward. The clinical director informed us that lengths of stay had been reduced and early discharges improved by implementing consultant cover for each week, with a consultant handover twice a day, seven days a week.

Learning from experiences, concerns and complaints

in 2015 parents we spoke with were aware of the process to raise a concern or make a formal complaint. We saw that information was clearly displayed for people who used the service and who wished to raise a concern or complaint. Staff we spoke with told us that concerns and complaints were discussed at ward or department level and actions were taken as a result of them. We saw evidence of this displayed in the ward areas. Staff members were able to give us examples of learning from feedback from patients and their relatives. One comment had been that there was a lack of age-related toys in the Rainforest outpatients department; the department was working with the play team at the time of our inspection to rectify this.

End of life care

Effective	Good
Overall	Good

Information about the service

Peterborough City Hospital does not have any dedicated wards for end of life care. End of life care is provided across the hospital wards and in the haematology/oncology day wards. The specialist palliative care team (SPCT) is a multi-professional group serving the catchment area of Peterborough, Cambridgeshire, Leicestershire, Lincolnshire, Rutland and Northampton.

The SPCT is a consultant-led multidisciplinary team that consists of two consultants in palliative medicine, and it is shared between Sue Ryder Thorpe Hall Hospice and the trust. Within the hospital are 2.2 whole-time equivalent (WTE) clinical nurse specialists (CNSs) and 0.6 WTE associate CNSs. There are also 0.6 WTE clinical psychologists, funded by the mental health trust. In addition there are chaplains, dieticians, occupational therapists and physiotherapists. The community team includes four CNSs and 1.8 associate CNSs supported by an administrator and managed by a 0.6 WTE CNS. The trust has close links including shared medical appointments with the local hospice.

During our inspection in 2014 we identified 37 patients in receipt of some form of end of life care. Of those patients, 26 were being cared for at the trust and 11 were in receipt of care at home from CNSs. We visited 12 wards where people were receiving end of life care. We spoke to four doctors, eight nurses and support staff. We also spoke with patients and relatives. During the course of the inspection, we discussed end of life care with small groups of staff. In addition, we visited the mortuary and hospital faith centre to talk to the chaplain about the service and the support available for those grieving.

At our follow up visit in June 2015 we visited four wards reviewed the records of six people and spoke with seven members of staff to ascertain what improvements had been made in the past year.

Summary of findings

In 2014 we found that the trust had a strong focus on end of life care. The trust had used CQUINs (Commissioning for Quality and Innovation targets agreed with the local commissioning groups) to develop and improve the service provided to patients at the end of their life.

The trust was clear with regard to the actions required to review and replace the Liverpool Care Pathway. The Amber Care Bundle was being piloted on two wards. The action plan demonstrated that it would then be rolled out across the trust to meet the Department of Health's guideline timeframe of July 2014.

The palliative care team was very committed and provided a service seven days a week. The team was alerted immediately to any admission of a terminally ill patient. There was very good multi-agency working and close working with both the community team and the local hospice.

Staff were clear about 'do not resuscitate' policies and documents viewed were appropriately signed. Equipment was available and clean, appropriate checks had been made and staff understood how to use the equipment.

The care provided to those who had died was excellent and led by a very passionate bereavement centre manager. In addition, the chaplaincy service and the faith centre provided support to both patients, their families and friends and staff of all faiths and cultural backgrounds.

The purpose of our follow up inspection in May 2015 was to check that the Amber Care Bundle had been rolled out throughout the trust, that pain management was being prescribed and administered effectively and communication over the preferred place of death had been improved. We found that a new lead for palliative care had been put in place and that they had supported

End of life care

and empowered the palliative care team to drive forward improvements and positive change. This meant that the effective domain had gone from requiring improvement to being rated as good.

Are end of life care services effective?

Good

We found that end of life services were effective. In 2014 we were concerned that the Amber Care Bundle had not been implemented and that patients did not always receive timely pain relief. In 2015 we found that the Amber Care Bundle had been rolled out to all areas, providing consistent, evidence based care for patients and patients had personalised care plans. Patient care and outcomes were measured by audit and we saw that pain relief for end of life patients was now effectively managed.

Evidence-based guidance

In line with the National End of Life Strategy (2008), the trust had begun to implement the five patient-centred tools to improve quality in end of life care. Following recent guidance from the Department of Health, the trust had stopped using the full Liverpool Care Pathway and had moved to piloting the Amber Care Bundle. When visiting the wards, it was clear that staff were aware of this and knew how to use the Amber Care Bundle even if it was not being used on their ward. The trust had listened to the experience of other trusts and noted that a maximum of two wards should be supported at any one time. Hospitals had failed when they had tried to implement the Amber Care Bundle too quickly. Staff on the two wards using the Amber Care Bundle felt that it was very helpful and understood that it would be rolled out across the trust following the four-month pilot. During our 2014 inspection it was noted that the Amber Care Bundle action plan that the trust had completed had not been implemented across all ward areas.

At our follow up inspection in May 2015 we found that the Amber Care Bundle had been successfully rolled out and implemented across the trust. We visited four wards where patients were receiving palliative or end of life care. We reviewed the records of six people and saw effective and appropriate use of the Amber Care Bundle and Personalised Care Plans (PCPs) in each area that we visited. Staff we spoke with were aware of their responsibilities in relation to supporting patients and their families. Regular input from the palliative care team was evidence in records as was detail about decision making that involved a multidisciplinary medical team and the wishes of patients

and their relatives. We spoke to the relatives of one person receiving palliative care who told us that their relatives care had been "….excellent throughout" and that all "interventions and documentation had been explained fully."

The trust may however find it useful to note that we heard, on two occasions, that due to a reduction in medical cover over the weekend it could be difficult to get decisions about transferring patients on to PCPs. This meant that there was a risk patients may not receive the most appropriate timely interventions and care over the weekend.

Monitoring and improvement of outcomes

Nurses and doctors across the trust praised the SPCT for its commitment and efficiency. There were clear systems in place that supported rapid identification of patients, which enabled the team to act swiftly and effectively. Patients on the wards felt that the staff were very helpful and provided them and their families with support through their end of life care.

However, during our 2014 inspection we found that communication on preferred place of death (PPOD) was poor in the trust and had been made part of the CQUIN for the preferred place of death. At that time we noted that subsequent auditing of the CQUIN had led to a change in the discharge sheet, and this has resulted in improved communication.

In 2015 we reviewed documentation and spoke with staff which confirmed that although improvements had been sustained further work was needed to make sure audit targets were consistently being met. We noted that regular auditing was taking place which looked at ensuring peoples preferred place of death was documented and that this was followed through as appropriate. The results of the most recent PCP audit showed that the 64% of patient's where it is evidenced that discussions re PPOD took place, 88% against a target of 100% were actioned and 71% of patient's against a target of 100% met their recognised PPOD. An action plan was in place to drive and monitor improvement.

In 2014 the trust participated in two National Care of the Dying audits. These were two-yearly audits in which trusts could participate to evaluate how compassionate and appropriate their care was for end of life care. It also provided evidence of high-quality care. The trust scored in line with the national average for those trusts that participated in 2011. In addition, there had been a number of clinical audits carried out by the trust in relation to patients in receipt of end of life care. The trust had action plans in place to address any deficits in care.

At our 2014 inspection one staff member felt that not enough emphasis was placed on pain control for patients receiving end of life care by the medical staff and that they could be quicker in responding to requests for pain control out of hours. The staff member said that the SPCT staff always responded quickly and patients were not left without pain control. A patient who had pain control via 'patches' said that: "I have to ask them to change the patches."

Our follow inspection in May 2015 recognised that significant improvement had been made in relation to pain relief for patients at the end of their life. We saw that the palliative care team had adapted the Abbey Pain Scale Tool and that this had been implemented across the trust. It was used appropriately in records that we reviewed. We spoke with six members of staff who were all familiar with the tool and confirmed that access to anticipatory medications and urgent pain relief was much improved. Two sets of relatives that we spoke with told us that they felt appropriate pain relief was being administered with one relative commenting "When my father became agitated the team ensured he was given a morphine infusion pump."

Sufficient capacity

Staff were supported with sufficient and up-to-date equipment to ensure that terminally ill patients experience good end of life care. The trust recently reviewed all the syringe drivers and purchased more up-to-date ones. A syringe driver is a piece of equipment that delivers medication over a set period of time. It is used in end of life care to continuously administer analgesics (painkillers), anti-emetics (medication to suppress nausea and vomiting) and other drugs where appropriate. This prevents periods during which medication levels in the blood are too high or too low, and avoids the use of multiple tablets (especially in people who have difficulty swallowing).

All staff had access to supervision and support and training was provided to all staff in the SPCT. Psychological and spiritual support were provided by the clinical psychologist and the chaplaincy team.

End of life care

The trust mortuary provided a very good service, not only for people who died in the hospital but also for those who died in the community. The facilities were very spacious and provided excellent areas for relatives. There were three large, well-furnished and decorated, private viewing rooms. Local and regional undertakers used the service and those spoken to during the inspection had a very high regard for the staff and service provided. They said that "it is brilliant here": access was easy, the relatives were more than pleased with the service and patients were treated with dignity and respect after death.

Multidisciplinary working and support

It was clear from speaking to members of the team and other staff that the team was well respected throughout the trust. Patients spoken to during the inspections praised their commitment and support. The clinicians confirmed that the SPCT was a multidisciplinary team that consisted of a consultant two days per week, two and a half CNSs with the support of Marie Curie and a clinical psychologist, and provided a seven-day service. The team was based with the community team on the trust site. The team worked with the transfer of care team to ensure that all patients' needs were facilitated in a timely manner. They also worked very closely with the mortuary and chaplaincy teams.

There were regular reflective sessions for staff that took place in the faith centre. These sessions helped staff review practice and learn from each other's experiences in a safe environment.

The team was supported by the Somerset database, System One for GPs and out-of-hours services, and E track. These three systems held registers and patient details of those people who were in need of end of life care. There were also joint education groups for sharing and learning. Out of hours, the team was supported by a regional on-call consultant for palliative care.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had thoughtfully engaged with children and young people in the service development and improvement of children's services.
- A new transition project had been agreed and was being supported by a CQUIN target for this year called "Ready Steady Go". This project aimed to build confidence and the understanding of children, younger people and their families' when transitioning into adult services.
- The trust was now meeting face to face increasing numbers of patients to discuss concerns or complaints.
- The Quality Assurance Committee was open to some external stakeholders including Healthwatch.

Areas for improvement

Action the hospital MUST take to improve

- Ensure records are accurate and updated to reflect the needs of patients and that care is given in line with records.

Action the hospital SHOULD take to improve

- Ensure that patients are adequately supported with nutritional needs.
- Ensure that medicines are stored correctly in all areas.
- Ensure that learning from incidents is disseminated consistently across different directorates and clinical areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider should ensure that all patient records are accurate and up to date.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.