Care Quality Commission

Sherwood Forest Hospitals NHS Foundation Trust

Newark 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	Requires improvement
Minor injuries unit	Requires improvement
Surgery	Requires improvement
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures.

We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Sherwood Forest Hospitals Foundation Trust was considered to be a high risk trust.

We carried out an announced visit on 24 and 25 April 2014 and unannounced, out-of-hours visits on 29 April and 9 May 2014.

Our key findings were as follows:

- Overall, services at Newark Hospital required improvement.
- The operational link between Newark and King's Mill Hospital was not robust.
- Staffing levels are not sufficient in some areas.

We saw several areas of outstanding practice including:

- Systems and processes in place in the pre-operative assessment department. The surgical department was very efficient and utilised their skill mix.

Importantly, the trust must:

- Ensure the use of current good practice in the Minor Injuries Unit
- Ensure there are appropriate numbers of staff in place for the care required.

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?
Minor injuries unit	Requires improvement 	The minor injuries unit at Newark Hospital was clean and staff followed hand hygiene procedures. There was sufficient equipment available, and a safe and effective system in place for its maintenance and repair. Staff had a good understanding of the trust's incident reporting system. Medicines were stored safely. Patients we spoke with were complimentary about the care they received. We saw that people were treated with dignity and respect. Staff were responsive to the needs of patients. Information was available along with translation services for patients for whom English was not their first language. Whilst local leadership appeared effective, there was no operational link with the trust's emergency department at the King's Mill Hospital site, and no overall strategy or shared management of services and risk.
Surgery	Requires improvement 	Surgery 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. Clinical management guidelines were reviewed and incorporated into local guidance to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients. Patients we spoke with told us that they felt that they received good quality care and were informed of any treatment required. We found that staff were responsive to people's individual needs. Appropriate assessments were carried out to ensure patients were able to provide valid consent before their planned surgery.

Summary of findings

			There was good leadership at local levels within the surgery services at Newark Hospital. However, there was no clear reporting structure for clinical governance to the senior management team and how the departments received feedback. Staff were not always supported and developed through the appraisal system.
End of life care	**Requires improvement**		The trust had not implemented guidelines, protocols or documentation to all wards that provided end of life care. There was no trust-wide co-ordinated multidisciplinary training in end of life care. Discussions about the decisions relating to end of life care were not always documented in the medical notes. Patient's choice for their place of care was not always documented. There were systems in place to provide planned discharges; however, there were no systems in place for a rapid discharge at end of life. There was no evidence of learning from complaints, incidents or audit of the care patients received at end of life. Staff had 24-hour access to the John Eastwood Hospice by telephone, for symptom control and advice. There were systems in place to refer patients to the Palliative Care team. There was no named executive director with a responsibility for end of life care, which meant that end of life care was not represented at board level or in the trust's vision or strategy.
Outpatients	**Requires improvement**		The trust had not implemented guidelines, protocols or documentation to all wards that provided end of life care. There was no trust-wide co-ordinated multidisciplinary training in end of life care. Discussions about the decisions relating to end of life care were not always documented in the medical notes. Patient's choice for their place of care was not always documented. There were systems in place to provide planned discharges; however, there were no systems in place for a rapid discharge at end of life. There was no evidence of learning from complaints, incidents or audit of the care patients received at end of life.

Summary of findings

Staff had 24-hour access to the John Eastwood Hospice by telephone, for symptom control and advice. There were systems in place to refer patients to the Palliative Care team.
There was no named executive director with a responsibility for end of life care, which meant that end of life care was not represented at board level or in the trust's vision or strategy.

Requires improvement

Newark Hospital

Detailed findings

Services we looked at:
Minor Injuries Unit and Urgent Care Centre; Surgery; End of life care; Outpatients

Contents

Detailed findings

Background to Newark Hospital

Sherwood Forest Hospitals NHS Foundation Trust provides healthcare services for a population of 418,000 people across Nottinghamshire (Mansfield, Ashfield, Newark and Sherwood), and parts of Derbyshire and Lincolnshire. Newark Hospital has 35 beds and two operating theatres, a minor operations room and a minor injuries unit.

Newark hospital is approximately 45 minutes travel from King's Mill Hospital.

The trust is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Nursing care
- Surgical procedures
- Treatment of disease, disorder or injury.

Staffing

The trust employs around 3,800 whole time equivalent (WTE) staff. Its annual sickness absence rate of 4.9% is the highest of the eight acute trusts in the East Midlands.

Newark Hospital has approximately 5% of the beds within the trust.

A comprehensive range of treatments is available on site. The trust offers an extensive range of consultant-led outpatient services, planned inpatient treatments, day-case procedures, diagnostic and therapy services as well as a Minor Injuries Unit / Urgent Care Centre. There are 35 beds available across two medical wards and 21 more in the surgical ward. There are two brand new pre-operative assessment and endoscopy centres which have already seen more than 3,000 patients benefit from the state-of-the-art facilities. The hospital receives full back-up from the teams at King's Mill and the services are wholly compatible.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality and Commissioning (Medical and Dental), Health Education England

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission

The team had 34 members, including CQC inspectors, managers and analysts, experts by experience who have personal experience of using or caring for someone who uses the type of service we were inspecting,, and medical and nursing clinical specialists.

How we carried out this inspection

During our inspection we visited King's Mill, Newark and Mansfield Community Hospitals.

We have identified, where appropriate, the site to which our findings refer.

We inspected this hospital as part of our in-depth hospital inspection programme. The trust was placed in special measures following an investigation in June 2013 led by Sir Bruce Keogh for NHS England into the quality of care and treatment provided by trusts that were persistent outliers on mortality indicators. A follow-up visit was carried out in December 2013.

We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Sherwood Forest Hospitals NHS Foundation Trust was considered to be a medium risk trust and an aspirant foundation trust.

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

Detailed findings

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital, and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 24 and 25 April 2014, and unannounced, out-of-hours visits on 29 April and 9 May 2014.

During our visit to the trust, we spoke with many people using the services, both as patients and as carers or relatives of patients. We also held two public listening events on 24 April in Newark and Mansfield. Approximately 50 people joined us to share their views and experiences of the trust.

During our visit, we held focus groups with a range of staff, including health care assistants, nurses, allied health professionals, non-executive directors, senior staff, junior doctors, trust governors, non-clinical staff and consultants. We talked with patients and staff at the three hospitals from a range of wards, theatres, outpatient departments, minor injuries and the A&E department. We observed how people were being cared for, and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held two listening events in Mansfield and Newark, where members of the public shared their views and experiences of the hospitals.

Detailed findings

Facts and data about Newark Hospital

Newark Hospital has a Minor Injuries Unit & Urgent Care Centre which offers immediate assessment and treatment for suspected broken bones, infections and non-traumatic joint pain with a wide variety of clinics are available at the hospital all headed by specialist consultants and nurses.

This location has been inspected recently. In 2011, it was found to be compliant on all 16 outcomes.

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Minor injuries unit

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Newark Minor Injuries Unit and Urgent Care Centre is open 24 hours per day, seven days per week, and offers immediate assessment and treatment for suspected broken bones, infections and non-traumatic joint pain.

Patients were treated in one of three resuscitation bays, or in one of the smaller treatment rooms on the unit. X-ray facilities were available between 8:30am and 9pm. Out of hours, X-ray staff were available on call. The unit had one private room which was used for patients who were distressed, or had specific needs which required greater privacy.

We visited all of these areas. We talked with two patients, their relatives, and four staff including nurses, and doctors. We observed care and treatment, and looked at treatment records.

Summary of findings

The minor injuries unit at Newark Hospital was clean and staff followed hand hygiene procedures. There was sufficient equipment available, and a safe and effective system in place for its maintenance and repair.

Staff had a good understanding of the trust's incident reporting system. Medicines were stored safely.

Patients we spoke with were complimentary about the care they received. We saw that people were treated with dignity and respect.

Staff were responsive to the needs of patients. Information was available along with translation services for patients for whom English was not their first language.

Whilst local leadership appeared effective, there was no operational link with the trust's emergency department at the King's Mill Hospital site, and no overall strategy or shared management of services and risk.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement

The minor injuries unit at Newark Hospital was clean and staff followed hand hygiene procedures. There was sufficient equipment available, and a safe and effective system in place for its maintenance and repair.

There may not be sufficient medical staff in the department and the trust had not responded effectively to an identified risk relating to trauma patients.

Incidents

- The staff we spoke with in the unit knew how to report incidents. They showed us that they had access to the trust reporting system, Datix.
- We saw evidence of incident reporting. We saw that this incident was discussed at a subsequent clinical management team meeting, and actions taken to ensure that the incident did not happen again.

Cleanliness, infection control and hygiene

- We saw staff wash their hands and use hand gel between patients.
- Hand gel was available at the point of care and at the entrance to the department.

Environment and equipment

- The environment in the unit was generally safe.
- There was a small area with toys and books available for children attending the unit to use. We saw that there was sufficient appropriate medical equipment available.
- Staff showed us daily and weekly checklists for equipment in the three resuscitation bays. These checklists had been fully completed.
- After 5pm and at weekends, when the hospital facilities were closed, the unit had the equipment to carry out blood testing. Staff were able to explain how this worked and to show us completed calibration charts for the equipment.
- Staff told us that equipment maintenance was carried out by a contractor. They showed us a system for reporting faulty equipment, which included yellow alert stickers to indicate a fault had been reported.

Medicines

- Medicines in the unit were stored correctly in locked cupboards or fridges. Temperature charts for these showed that they had been checked and recorded daily as required. Staff told us that medicines were checked by pharmacy staff to ensure stock levels were appropriate. This meant that medicines were stored safely.

Records

- The trust's risk register mentions the risk of "delay in transferring patients from Newark's Urgent Care Centre". This is listed as a clinical risk with daily occurrence. It states, "there is a clinical risk to patient safety since the introduction of the Urgent Care Centre at Newark Hospital.
- Patients who require acute care are transferred to another provider and East Midlands Ambulance Service NHS Trust (EMAS) have, on occasions, been unable to transfer these patients within the agreed time frame".
- The risk register also records a risk most recently reviewed on 1 October 2013. This risk states that there was "no formal trauma protocol for self-presenters in MIU. Staff are instructed to repatriate patient via East Midlands Ambulance Service (EMAS) to nearest Emergency Department. Awaiting ratification of trauma protocol by Emergency Care Service Director".
- We saw minutes of a clinical governance meeting from 21 February 2014, which stated, "the revised EMAS protocol had been taken to Clinical Management Team (CMT) and has now been forwarded to the Medical Director for signature." However, at the time of our visit staff showed us a copy of the admissions protocol for ambulance staff. This did not include arrangements for the transfer of patients to the nearest emergency department. The document was a draft. There was no implementation or review date, and the information about senior staff was out of date. We were not shown any evidence of an agreed trauma protocol for the unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy on capacity to consent, and that staff had received training in this area.
- Staff told us how they supported patients who had difficulty in communicating.
- There were children present in the unit and staff followed appropriate procedures to obtain consent from their parents to treat these patients.

Minor injuries unit

Safeguarding
- Nursing and medical staff told us they knew what to do if they had a safeguarding concern about a patient.
- Staff also knew about the trust's safeguarding systems and processes, and were able to show us the relevant documentation.

Mandatory Training
- Staff at the unit had received training required in children's emergency care.

Management of Deteriorating Patients
- Staff told us that they provided on-call cover as a crash team for the main hospital in the case of a patient suffering a cardiac arrest.
- One staff member told us that they considered this potentially unsafe if there were two patients who were unwell simultaneously.
- Staff told us that if patients present at the minor injuries unit with a life threatening condition such as cardiac arrest, they would attempt to stabilise the patient's condition before calling for an ambulance.
- They also told us that the ambulance trust has been slower arranging transfer than they would have hoped, because patients were considered to be lower priority because they were already in a hospital.
- We asked if they had an agreement with East Midlands Ambulance Service (EMAS) regarding these transfers. The document we were given was a draft document with no implementation or review date, and information on it was out of date. The document was a detailed description of referral criteria, not an agreement about the transfer of seriously ill patients. We were told later that there is a Facility Transfer protocol in place dated 20.9.12. There is also an escalation policy where ambulances are not received in a timely way.
- It was not clear how long staff would wait to alert the ambulance.

Best practice would be to alert the ambulance immediately the patient had an arrest. This meant that patients' health, safety and welfare was not protected when more than one provider was involved in their treatment, or when they moved between different services.

Medical staffing
- A locum doctor had been on duty the previous weekend who had never worked in an emergency or minor injuries unit before. They said that this was not appropriate and put an extra burden on nurses. This meant that there may not be enough qualified, skilled and experienced staff to meet people's needs.
- The minor injuries unit was staffed by one middle grade doctor and four nurses. A doctor told us that they felt that one doctor on duty at the weekend was "unsafe and inhumane" as the work load was too much, with up to 70 patients arriving in a 12 hour period. They told us that they had raised their concern with senior doctors and managers, but there were no plans to address it.

Major incident awareness and training
- We saw that the trust had planned for foreseeable emergencies, such as adverse weather, and that they had written procedures in place.

Are minor injuries unit services effective? (for example, treatment is effective)

Not sufficient evidence to rate

There was not an effective, evidence-based pathway in place for patients arriving at the unit with life threatening conditions.

There was no evidence of collaborative working with the trust's emergency department team based at King's Mill Hospital.

Evidence-based care and treatment
The minor injuries unit was attended by adults and children.

- The nurses told us that they had completed advanced life support (ALS) and the European paediatric life support course (EPLS). This training is recommended for nurses treating children.

Multidisciplinary working
- Staff told us that they did not any receive training jointly with the emergency department at the trust's King's Mill Hospital location.
- They also told us that although they treated children in the unit, they did not have any contact with the children's emergency department at the trust's King's Mill Hospital location.

Minor injuries unit

- They also told us that they received no support from the trust's paediatric nurses or paediatricians. However, they did receive a visit once per month from the trust's paediatric liaison facilitator, who reviewed records of children's attendances at the unit.

Are minor injuries unit services caring?

Good

The patients we spoke with were very positive about the service at the minor injuries unit. They told us that they were seen promptly and that communication was good.

Chaplaincy and bereavement services were available at Newark Hospital to support patients and their relatives.

Compassionate care

- The patients we spoke with were very positive about the service at the Minor Injuries Unit. They told us that they were seen promptly and that communication was good.
- NHS Choices had an overall service user rating of 4.5 / 5 for the unit. Comments on their website included:
  - "Visited urgent care unit today and was VERY impressed. Helpful caring staff who went out of their way to explain things. Very quickly seen could not ask for more. A big thank you to all the staff."
  - "I injured my ankle after a fall at my caravan and I came to the Minor Injuries Unit on the following day after an X-ray I was told it was broken. Because it was swollen they put a back slab plaster on it and told me to return 4 days later. I then saw the consultant who explained everything to me very clearly and I am most impressed with my treatment. Thank you."
  - "I just wanted to thank the staff at the Minor Injuries Unit for their superb service. I went in with a suspected broken finger. The lady at reception was very kind and immediately put me at ease. Within 20 minutes of arriving I was seen by a lovely nurse who again was very kind. Within 40 minutes of arriving I had been X-rayed and within 2.5 hours I had been treated, given an appointment to the fracture clinic and was on my way."
  - "The staff were really excellent with how they treated everyone and I was impressed by their attitude and the speed of service. Thank you very much indeed."
- Chaplaincy and bereavement services were available at Newark Hospital to support patients and their relatives.

Patient understanding and involvement

- We saw evidence that all patients received a letter for their GP when they were discharged from the unit.
- We observed staff explaining treatment options to patients, and involving them and their relatives in their care and treatment.

Emotional support

- Although patients' details were taken on arrival in a public area, staff told us that they were aware of the confidentiality issues. They showed us a special screen on the computer which restricted what information was visible to other patients.
- They also told us how they could use the small private room if they felt it was necessary.
- We observed patients being received into the unit and we saw staff take confidential information discreetly.

Are minor injuries unit services responsive to people's needs? (for example, to feedback?)

Good

Services at the Minor Injuries Unit met people's needs. Information was available to patients about their treatment and how to make a complaint or offer a compliment.

Meeting people's individual needs

- We saw posters in the department for an interpreter service for patients whose first language was not English. Staff told us that there was an interpreter available by telephone.
- Some of the health information leaflets, such as head injury advice, were available translated into languages appropriate to the local community. We saw that these leaflets were available in a waiting area. Staff told us that some of these were translated into other languages.

Learning from complaints and concerns

- We saw posters displayed around the department, which explained to patients how they could make complaints and give feedback.
- Leaflets were available for patients to take away with them.
- Staff were aware of how to manage complaints and how to support patients who wished to complain.

Minor injuries unit

Are minor injuries unit services well-led?

Requires improvement

Although the trust had recently introduced a 'Quality for All' programme, focused on shared values and behaviours, none of the staff we spoke with in the unit were aware of this initiative. There was no operational management link with the emergency department at King's Mill Hospital, and no evidence of shared learning or practice. Staff were unclear about governance arrangements for the unit in relation to the trust's senior managers.

Vision and strategy for this service

- The trust had recently introduced a 'Quality for All' programme, focusing on shared values and behaviours. The intention of the programme was to support staff to provide the best patient experience and outcomes.
- This was launched in March 2014, but none of the staff we spoke with in the MIU were aware of this initiative.

Governance, risk management and quality measurement

- NHS Choices website states "the hospital receives full back-up from the teams at King's Mill and the services are wholly compatible". However, we were told that the minor injuries unit is managed by the Newark management team.
- There was no operational management link with the emergency department at King's Mill Hospital. Staff at Newark Hospital and at King's Mill Hospital confirmed that there was no communication, support or shared practice between the departments, other than for individual patient handovers.
- Local leadership included a department manager who reported to a matron at Newark Hospital and to the hospital manager.

Leadership of service

- Staff we talked with knew who the local leadership team were, but they were less clear about how they reported into the trust's senior managers. Staff told us that they worked well together as a team and supported each other.

Culture within the service

- We saw that staff on duty during our visit were supportive of each other and communication between them was effective .

Surgery

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

Information about the service

The surgical division at Newark Hospital consisted of a 29-bedded ward, a pre-operative assessment department and two operating theatres. The hospital provided a range of surgery, including orthopaedic, ophthalmology, urology, general surgery, podiatry and ear, nose and throat (ENT).

We visited the ward, the pre-operative assessment department and operating theatres. We talked with three patients and seven staff, including nurses, consultants, and allied healthcare professionals. We observed care and treatment. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Surgery 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.

Clinical management guidelines were reviewed and incorporated into local guidance to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

Patients we spoke with told us that they felt that they received good quality care and were informed of any treatment required.

We found that staff were responsive to people's individual needs. Appropriate assessments were carried out to ensure patients were able to provide valid consent before their planned surgery.

There was good leadership at local levels within the surgery services at Newark Hospital. However, we were unable to determine from the teams a clear reporting structure for clinical governance to the senior management team and how the departments received feedback.

Staff were not always supported and developed through the appraisal system.

Surgery

Are surgery services safe?

Requires improvement

Surgery 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.

Incidents

- Nursing and medical staff were knowledgeable about the reporting process for incidents using Datix (the trusts incident reporting system).
- Staff also informed us that a feedback poster of incidents reported was displayed. We saw this poster displayed and noted that this information was up to date.
- This meant that incidents were being reported, and staff were informed of what action was taken as a result, or if any lessons were learnt
- Patient safety boards displayed in the ward showed the figures for the previous month on specific areas, such as the number of pressure ulcers, the number of falls and the number of medication incidents. This demonstrated the safety of the ward to all patients.
- We were told that the paper-based system of surgical safety checklists was in place in the operating theatres. This included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors.
- However, we were told that medical staff were not fully engaged with the WHO process, resulting in them not participating in all aspects of the surgical safety checklist. We were also informed that briefings before and after surgery were not yet mandatory in the trust, and it was intended in the near future to make it mandatory.

Cleanliness, infection control and hygiene

Infection rates (September 2013–January 2014) for surgery services at Newark Hospital demonstrated that there had been no incidents of MRSA or hospital-acquired Clostridium difficile.

- The trust carried out various audits, which included infection control. The results for December 2013 and January 2014 for compliance with hand hygiene demonstrated that surgery services at Newark Hospital were consistently high; in January 2014 100% was achieved.
- Staff wore appropriate personal protective equipment (PPE) when required, and that staff adhered to 'bare below the elbow' guidance in line with national good hygiene practice.
- We saw that there were sufficient infection control facilities and that the premises were visibly clean.

Environment and equipment

- We saw that checks for emergency equipment, including for resuscitation, were carried out on a regular basis.
- In the operating theatres, we saw that the equipment was clean, and that equipment could be easily identified as having had a recent service and an electrical portable appliance test.
- Within the operating theatres, we noticed that there was a considerable amount of equipment stored in the fire exit corridor. This prevented easy access to an emergency exit in the case of an emergency, such as a fire.
- This would also delay patients being moved to a safe environment who are potentially vulnerable due to receiving surgery.

It was also noted that there was limited space within the pre-operative assessment department due to the design and layout

Records

- Monthly audit were undertaken within the nursing metrics for theatres to identify if a team brief was carried out, and if the surgical safety checklist was completed accurately; this provided assurance of safety of nursing aspects around the operation. A random sample of 10 checklists was completed each month

Mandatory training

- Training attendance rates for the ward, as of January 2014, showed that uptake of mandatory training was low. This included information governance (72.7%), infection control and hand hygiene (81.8%) and medicines management (90.5%).
- This meant that not all staff required to attend appropriate training had done so to ensure they had the most up-to-date knowledge to provide effective care and treatment for patients.

Surgery

- We noted that there were potential privacy issues on the ward. We noticed that the clear windows meant that there was clear visibility into the ward from the street. However, patients had not raised this as an issue.

Nursing staffing

- Staffing levels were consistent with the needs of the patients to ensure patient care was delivered safely.
- Staffing figures for the ward demonstrated that there were a total of two vacancies for the surgical ward which related to registered nurses. This data from the trust was as of January 2014. This meant that the planned staffing levels were sufficient for patient needs; however, due to staff vacancies there was a potential risk to patient safety.
- Within operating theatres, we were informed that there was flexible theatre session allocation to allow for annual leave and non-availability.

Medical staffing

- The divisional risk register also identified medical staffing as a risk, and although actions were in place to use locums, there was still a risk that the locum would not attend the booked session. This could have an impact for patients on the wards that they may not receive sufficient clinical support.

Major incident awareness and training

- The surgery services had various business continuity plans in place.
- The divisional risk register highlighted some concerns over the availability of electricity at Newark Hospital, as only half of the site had emergency back-up electricity supply in the case of a power failure. This would affect the catering department and administration offices in particular; no further actions were identified to mitigate potential risks.

Are surgery services effective?

Good

Clinical management guidelines were reviewed and incorporated into local guidance to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

Evidence-based care and treatment

- We saw that guidance was produced for pre-operative assessments in line with best practice, including the National Institute of Health and Care Excellence (NICE) and the Association of Anaesthetics Great Britain and Ireland.
- This meant patients could be assured that appropriate assessments would be carried out to ensure the patient was medically fit for their operation.

Patient outcomes

- We saw that a nursing metric audit was carried out on a monthly basis for the ward and for operating theatres. The audits on the wards covered 12 areas, such as nutrition, privacy and dignity, and falls.
- The audit results demonstrated from September 2013 to January 2014 that the majority of required standards were achieved each month; this included compliance with falls management, medicines management and nutrition. The main areas for improvement were continence management, safeguarding, tissue viability management (the prevention of pressure ulcers), pain management and dementia.
- Performance data in the operating theatres included information around the number of cancellations, delays in theatre starts and averages of operating times. We were informed that this data was collated by an external consultancy, who were reviewing the performance and efficiency of operating theatres. This information was also newly displayed.
- Staff told us that there were discrepancies in the data, such as operating times, and there were plans in place to improve it. The reasons for delays and cancellations were also not clearly captured.

Multidisciplinary working

- Staff informed us that they worked flexibly and sometimes provided support to medical outliers.

There was allocated physiotherapy and occupational therapy support to the surgical ward at Newark Hospital.

Surgery

Are surgery services caring?

Good

Patients we spoke with told us that they felt that they received good quality care and were informed of any treatment required.

Compassionate care

- We spoke with three patients during our inspection. Patients told us that they were entirely happy with the service they had received.
- We observed patients being treated with dignity and compassion.

Patient understanding and involvement

- Patients told us that they were involved in their care and their treatment had been discussed with them.
- One patient told us that they had received information leaflets relating to their operation, which provided useful information for them to read.

Emotional support

- Staff informed us that as a team there was good communication between the different healthcare professionals and with the patients.
- Patients confirmed that they were happy with the communication from staff members.
- Chaplaincy services were available for patients at Newark Hospital; a member of the chaplaincy service was allocated to the hospital for one day a week.
- During the pre-operative assessment, patients were asked if they had any anxieties. This meant that staff could talk through any anxieties at that time, to provide reassurance to the patient, and also note this for the patient's admission for surgery.

Are surgery services responsive?

Good

We found that staff were responsive to people's individual needs. Appropriate assessments were carried out to ensure patients were able to provide valid consent before their planned surgery.

Service planning and delivery to meet the needs of local people

- Pre-operative assessment documentation ensured that patients consented for their procedure and that they were fully aware of decisions made and why.
- At this stage, staff were able to assess if patients had the necessary mental capacity, and if there were any concerns and a mental capacity assessment was required.

Access and flow

- Theatre utilisation at Newark Hospital was less than expected for all surgical specialties, which was also reflected in the day case rate.
- We saw that staff had recently been requested to review the day case information and put actions into place.
- Patients told us that they had no concerns in being seen at Newark Hospital and felt that they were seen quite quickly.

Meeting people's individual needs

- All patients who were to undergo planned surgery were seen by a nurse in the pre-operative assessment department. The appointment was held in private to allow for any questions the patient may have, and also to protect the patient's confidentiality.
- This meant that if there were any concerns about the medical welfare of the patient, appropriate action could be taken or further appointments made as needed. This was to ensure patients met the criteria for elective surgery at Newark Hospital.
- Any patients who were unsuitable to have their surgery at Newark Hospital, due to co-existing conditions which could increase the risk of complications, were referred back to the main site at King's Mill Hospital.

Learning from complaints and concerns

- We saw that the surgical ward had not received any complaints between September 2013 and January 2014.
- We reviewed the data from the Patient Advice and Liaison Service (PALS), which demonstrated that most comments received were positive. However, it was unclear how this information was shared with staff and how it was shared with the planned care and surgery division senior management team.

Are surgery services well-led?

Surgery

Requires improvement

There were no clear reporting structure for clinical governance to the senior management team and how the departments received feedback.

Staff were not always supported and developed through the appraisal system.

Vision and strategy for this service

- The trust had recently implemented a new quality for all strategy, which included new behaviours and values to ensure staff deliver quality care at all times.
- Staff we spoke with were unclear of the direction and the immediate plans and strategy for Newark Hospital, specifically relating to elective surgery. This was due to the withdrawal of inpatient elective surgery.

Governance, risk management and quality measurement

- There was no clear reporting structure for quality and performance issues for surgery services at Newark Hospital into the planned care and surgery divisional clinical governance meetings.
- We were unable to see how risks were escalated to the appropriate persons and how action was then taken.

Leadership of service

- Leadership at a local level within the ward and operating theatres was good, and staff felt supported by their line managers. Although, due to the lack of communication about the immediate future of elective surgery, we were unable to see how the services were led at a senior level.

Public and staff engagement

- Ward and department leaders were passionate about patient care and developing the way patients were cared for and treated. This was reflected in the positive comments PALS received and which we reviewed.
- Staff members raised with us their concerns about the changes to the operations that would be carried out at Newark Hospital in the near future.
- Staff informed us that there was no clear communication about the future case loads, and with the imminent changes, as they still did not understand how the changes would affect them.

Innovation, improvement and sustainability

- Nursing and medical staff worked well together and knew how to report incidents as and when required. However, it was unclear how this information was then used to learn and improve the services in place.
- The trust appraisal rate for planned care and surgery was 75.5%, as of December 2013; this data is not specific to Newark Hospital. The surgical ward, as of January 2014, had an appraisal rate of 72%.
- This meant that staff were not always receiving appropriate support and development through the use of the appraisal system.

End of life care

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

Information about the service

Newark Hospital has three adult wards, and there was one ward where people would receive end of life care. Newark Hospital experiences around 30 deaths per year. The Specialist Palliative Care team was based in the community provided by John Eastwod Hospice, which is not part of Sherwood Forest Hospitals NHS Foundation Trust.

We visited one ward at Newark Hospital. We met three patients. We spoke with 10 members of staff including nurses, healthcare assistants, consultants, doctors, allied healthcare professionals, support staff and senior managers. We visited the mortuary and the mutli-faith centre. We looked at care records for people who had died at Newark Hospital. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the Trust's end of life care.

Summary of findings

The trust had not implemented guidelines, protocols or documentation to all wards that provided end of life care.

There was no trust-wide co-ordinated multidisciplinary training in end of life care.

Discussions about the decisions relating to end of life care were not always documented in the medical notes. Patient's choice for their place of care was not always documented.

There were systems in place to provide planned discharges; however, there were no specific systems in place for a rapid discharge at end of life.

There was early evidence of learning from complaints, incidents or audit of the care patients received at end of life.

Staff had 24-hour access to the John Eastwood Hospice by telephone, for symptom control and advice. There were systems in place to refer patients to the Palliative Care team.

There was a named executive or non-executive director with a responsibility for end of life care, however this was a very new appointment at the time of our inspection; staff were not fully aware. This meant that end of life care was not previously represented at board level or in the Trust's vision or strategy.

End of life care

Are end of life care services safe?

Requires Improvement

The Trust had an end of life lead, however, there had not been any involvement at Newark Hospital. There was no Trust-wide co-ordinated multidisciplinary training in end of life care. Discussions about the decisions relating to end of life care were not always documented in the medical notes and patient's choice for their place of care or death was not always documented.

Incidents

- There have been no recent 'never events' or serious incidents in respect of end of life care. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- Staff were encouraged to report incidents.

There were systems in place to feedback incidents reported about end of life care to the department involved; however, they were not shared with all staff that provided end of life care.

Medicines

- The medicines used to treat symptoms which may occur at end of life were available, and syringe drivers were available to deliver sub-cutaneous medication.
- The protocols for prescribing medicines to treat symptoms which may occur at end of life were available on the hospital intranet site. Most of the doctors were aware of the protocols and had used them.
- The medication charts for one patient who had received end of life care did not have any anticipatory medicines prescribed as per the trust protocol.
- This meant that not all patients who were receiving end of life care were prescribed medicines to treat symptoms that may arise.

Records

- The trust documentation of Allow a Natural Death (AND) forms were signed by a senior member of medical staff.
- Discussions about the decisions relating to end of life care were not always documented in the medical notes.
- Patients' choice for their place of death was not always documented. This meant that there was not a clear record of why the decision had been made to allow a natural death and there was no clear evidence that patients and their families had been involved in the decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The evidence of assessing patients' mental capacity to have discussions about decisions at end of life had not been recorded.
- Where patients had been assessed as not having the ability to communicate, there was no evidence of a mental capacity assessment or a meeting to discuss the patient's best interest.
- This meant that decisions about care at end of life had been made without a record showing that consideration had been made for their ability to be involved.

Mandatory training

- There was evidence of multi-disciplinary education and training programmes for end of life care. A number of sessions on Induction Training days have been provided for new staff not implementing the end of life care tools such as GSF and ACB.
- The last training delivered for end of life care was over one year ago, and there was none planned for the future.
- This meant that new staff had not received end of life training, and were not booked onto any such training.
- Communication courses were on offer at the neighbouring hospice; we found that some members of staff had attended this training; however, there was no trust record of who had attended the training or a strategic programme to ensure staff received communication training.
- Junior doctors received half an hour's training in end of life care during their rotation. Syringe driver training was available to staff.

Are end of life care services effective?

Requires Improvement

The Trust had not implemented guidelines, protocols or documentation to the wards that provided end of life care. There was no consistency in the level of care that was provided.

End of life care

Evidence-based care and treatment

- The trust had followed national guidelines to phase out the use of the Liverpool Care Pathway (LCP) to document end of life care by July 2014.
- In April 2014 staff throughout the trust had been advised by email to use the principles of the LCP to provide end of life care until local guidance could be implemented. This reiterated an email sent in July 2013.
- Staff at the trust used standard care plans to assess, plan and evaluate care at the end of life.
- Documentation about discussions with patients and their families were documented in the medical notes. Decisions made about care at end of life were also documented in the medical notes.
- There were no guidelines to follow and not all staff had received training, which meant that end of life care depended upon the previously gained knowledge and skill of the team on the ward.
- There was no consistency with the delivery of end of life care, as there was no guidance for staff to follow; for example, some patients had documented discussions and decisions about end of life care planning, and others had not.
- Medical staff had access to the Specialist Palliative Care team; however, not all doctors were aware of how to contact the team.
- Timely referral to the Specialist Palliative Care team relied on ward staff being aware of the role of the Specialist Palliative Care team. There was a single point of access to make all referrals.

Patient outcomes

- The hospital contributed to the National Care of the Dying Audit, the results of which are to be published on 15 May 2014. The audit included a local survey of bereaved relatives or friends perspectives.
- There had been no audits to monitor the completion and rationale for Allow Natural Death (AND) forms.
- There was an audit by the resuscitation department in June 2013, which found that lack of end of life care planning had led to the cardiac arrest team being asked to resuscitate patients where there could have been discussions and decisions to allow a natural death.
- There was no evidence of this information having been shared with the end of life team or any action taken as a result.
- There were no audits to measure the trust's performance in delivering end of life care against the outcome set out by the Leadership Alliance for the Care of Dying People.
- We spoke with the end of life lead who told us that they had intended to carry out an audit of 20 sets of patients' notes; however, the methodology had not been developed.

Multidisciplinary working

- The ward had multidisciplinary team (MDT) meetings. End of life care was discussed at these meetings and decisions, such as the ceiling of interventions such as antibiotics, allowing a natural death, nutrition, and where patients would receive their care, were made.
- The Specialist Palliative Care team held their own Multidisciplinary team meetings weekly, all new patients who had been referred to them, and any particular patients with complex needs, were discussed.

Seven-day services

- The Specialist Palliative Care team were available 9am-5pm Monday to Friday.
- In addition there was a reduced service available at the weekend from 10am-4pm.
- Out of those hours support was provided via a telephone hotline to the local hospice.

The chaplaincy service was available two days per week at Newark Hospital.

Are end of life care services caring?

Good

Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found patients had chosen to stay at Newark Hospital for their care.

Compassionate care

- We found patients had chosen to stay at Newark Hospital for their care.
- Normal visiting times were waived for relatives of patients who were at their end of life.

End of life care

Patient understanding and involvement

- Where detailed discussions had taken place with patients and families, these were documented very briefly in the notes. However, one patient's notes did not contain any information about the communication with the family.

Emotional support

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly. Care and comfort rounds were carried out regularly to ensure patients were well cared for.

Are end of life care services responsive?

Requires Improvement

There were systems in place to provide planned discharges; however, there were no systems in place for a rapid discharge at end of life. There were no systems in place to discuss complaints, there had been no Trust-wide actions taken in response to end of life complaints.

Service planning and delivery to meet the needs of local people

- The discharge co-ordinator was in the process of setting up systems with departments to facilitate rapid discharge at end of life, including transport, equipment store and continuing healthcare.
- This meant that communication between departments could be improved to speed up the process of rapid discharge at end of life.

On discharge, a letter was sent to the GP detailing the events of the admission. The computer system was updated at the time of a patient's death and an automatic stop was placed on any outpatient appointments.

Access and flow

- Patients were seen by the Specialist within 48 hours of referral, and where needed, they were seen at short notice.
- Staff could access medical and nursing advice from the hospice by telephone.
- Where possible, side rooms were prioritised for patients at their end of life.
- There was a 'fast track' system, whereby patients who had been identified as in their last 12 weeks of life could be referred to the discharge co-ordinator, who specialised in discharging patients to their preferred place of care.
- All the staff we spoke with understood how the fast track worked and had seen patients discharged home. The discharge co-ordinator was knowledgeable and had some systems in place to facilitate discharge home within a week.
- There were no formal arrangements in place with all the services to ensure that all stages of the discharge were available for patients requiring a fast track discharge.
- There had been no audit to demonstrate how many patients were discharged to their preferred place of care or the time it took to discharge patients.

Meeting people's individual needs

- Interpreters were available when necessary.
- The bereavement suite provided practical advice for the days immediately after a patient had died.
- There were systems in place for patients who had no family.
- Bereavement counselling was only available where patients had been referred to the Specialist Palliative Care team, as this service was provided by the hospice. All other families were referred to their own GP.
- Where possible, nurses had accommodated families' needs, so that they could stay with their relatives whilst receiving end of life care.

Learning from complaints and concerns

- Complaints received concerning end of life care were handled by the trust in line with their policy. Newark Hospital had their own governance meetings, where complaints about their service could be discussed.
- However, as there were no end of life care governance meetings to discuss complaints; there had been no trust-wide actions taken in response to end of life complaints.
- This meant that the trust had no system in place to learn from complaints about end of life care, and no opportunity to share the learning throughout the trust.

End of life care

Are end of life care services well-led?

Requires Improvement

Very recently, the executive director of nursing and quality had been appointed as board level lead for end of life care.

Vision and strategy for this service

- There had been a management plan for developing end of life care created in August 2013. The documentation for this plan demonstrated that some of the target goals had been missed and re-arranged over a longer time span.
- Very recently, the executive director of nursing and quality had been appointed as board level lead

Governance, risk management and quality measurement

- There were no governance meetings held for end of life care. The trust recognised in the trust mortality group meeting in February 2014 that the number of expected deaths and those with palliative care needs need to be accurately identified.
- No member of the end of life team attends the mortality meetings.
- Complaints and incidents were discussed at Newark Hospital governance meetings, but end of life audits and quality improvement projects, were not discussed. There was no system, to feedback complaints to all staff who provide end of life care, to facilitate learning.
- There were no governance meetings held for end of life care. The trust identified in the trust

Leadership of service

- The end of life care team comprised of an end of life lead who was appointed in August 2013; she had support of a deputy executive director of nursing and quality.
- There was a respiratory consultant who had shown support and interest in implementing the pilot documentation on four wards.
- There was a named discharge co-ordinator for end of life care.
- Staff were unable to name the end of life lead, but they were able to name the discharge co-ordinator. Staff did not know how end of life was developing within the trust.
- The Specialist Palliative Care team was based at the John Eastwood Hospice; the end of life lead could access this team for advice and consultation.

Culture within the service

- Staff relied on end of life experience within their own teams, and sought assistance from the Specialist Palliative Care team.
- Staff saw the provision of good end of life care as a priority; however, there was little guidance, protocols or documentation available from the trust.
- There had been very little engagement with the staff about end of life care.

Innovation, improvement and sustainability

- There had been no opportunities for staff to have an input into the provision of end of life care in the trust.

Outpatients

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provided outpatient services to 337,068 patients in the year April 2012 to March 2013. Clinics are held at King's Mill Hospital in Sutton-in-Ashfield, Newark Hospital, Mansfield Community Hospital, and Ashfield Health Village. The departments are staffed by reception staff, doctors, specialist nurses, nurses, therapists and support workers. Student nurses and therapists attend outpatients on placement as part of their training.

We inspected the outpatient services provided by Sherwood Forest Hospitals NHS Foundation Trust at Newark Hospital. We spoke with 10 patients, two relatives and 18 staff, including nurses, healthcare assistants, consultants, doctors, allied healthcare professionals, support staff and senior managers. We received comments from our listening event, and from people who contacted us to tell us about their experiences; we reviewed performance information from, and about, the trust.

Summary of findings

Newark outpatients departments were clean and staff washed their hands before attending to patients. Patient records were primarily paper files, which sometimes caused a problem when patients' records were not available at time of their appointment, as the notes were at King's Mill Hospital. Staff knew how to, and were encouraged to, report incidents. Not all staff in the directorate governing outpatients had completed their mandatory training.

There were a wide range of clinics, with most patients receiving their appointments within target times. Staff were competent.

Patients were treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink, and transport arrangements. Emotional support was available from nursing staff.

Most patients had access to outpatient services within times set by national guidelines. Telephone reminder systems were only available to those patients who had mobile phones. Patients did not get the opportunity to choose Newark Hospital in the 'choose and book' system provided to them by their GP, even though this was their preference and the services were available. Staff aimed to deal with complaints as they occurred to

Outpatients

prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines.

Newark Hospital service provision was changing, staff said that they did not have a voice, and they had not been consulted about the changes. The new trust vision had not been embedded at the hospital.

Staff communication between Newark Hospital and King's Mill Hospital showed, at times, a lack of respect for each other. Staff culture within Newark Hospital was supportive.

Are outpatients services safe?

Requires improvement

Newark outpatients departments were clean and staff washed their hands before attending to patients. Patient records were primarily paper files, which sometimes caused a problem when patients' records were not available at time of their appointment, as their notes were at King's Mill Hospital. Staff knew how to and were encouraged to report incidents. Not all staff in the directorate governing outpatients had completed their mandatory training.

Incidents

- There have been no recent 'never events' or serious incidents reported in outpatients or radiology.
- All staff we spoke with knew how to report incidents and were encouraged to do so by their managers. Staff told us they would be confident in raising any concerns with their managers. Heads of departments met regularly to discuss compliments, complaints and incidents.

Cleanliness, infection control and hygiene

- Outpatient areas appeared clean and well organised. We observed that 'bare below the elbow' policies were adhered to, and we saw staff regularly wash their hands and use hand gel between patients.
- There were adequate toilet facilities which were clean.

Environment and equipment

- The environments in the outpatient areas were safe and fit-for-purpose. All areas were easily accessible.
- Resuscitation trolleys in outpatients were centrally located and checked regularly

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Patients were adequately counselled for new medication and written information was given.

Records

- Facilities for storage of patient's notes at Newark Hospital were inadequate. There was little storage space, which meant some patients' notes were stored on the floor.

Outpatients

- Where patients had previously received treatment from the trust's other hospital at King's Mill Hospital, their notes were not available for their clinic appointment at Newark Hospital. Staff had recognised this, and had discussed the issue at the governance meeting in November 2013; however, it was not clear what action had been taken. This meant that there was a risk that patients whose notes were stored at King's Mill Hospital would not have their medical notes available at their outpatient clinic appointment at Newark Hospital.
- Regular audits were not undertaken to monitor availability of records. This meant that there was no record of how many patients did not have their medical notes available. The trust was planning to implement electronic patient records in October 2014.
- Patients' results of tests, such as 24-hour heart monitoring, were not always available from King's Mill Hospital for their follow-up appointment at Newark Hospital.
- Diagnostic data from all areas of the trust were available electronically, but were printed out so that they could be filed in patient notes. There was an issue with printed results not being filed in patient notes properly; the clinical management team planned to carry out regular reviews of filing in case notes stores, Pathway Co-ordinator offices and wards.
- Patients completed a questionnaire about their medical history before they attended clinics as a new patient.

Mandatory training

- Information relating specifically to Newark Hospital staff only was not available. Compliance with all mandatory training for the diagnostic and rehabilitation division in the trust, as of 31 January 2014, was 70%. The lowest attendance rates for training that was required to be renewed were within escort training (48%), fire training (64%) and slips, trips and falls (65%). Whereas the highest attendance rates were within mental capacity act (94%), safeguarding adults (94%) and safeguarding children level 2 (90%). We also noted that for doctors that were required to attend MRSA and C. difficile training, the attendance rates were 13% and 16% respectively. Staff at the pathology governance meeting in January 2014 had discussed the issue of mandatory training compliance; they identified that there were not enough available dates within the training and development department, and this had been escalated to the performance management meeting. This meant not all staff required to attend appropriate training had done so to ensure they had the most up-to-date knowledge to provide effective care and treatment for patients.

Nursing staffing

- Staffing consisted of a comprehensive skill mix, which provided for patient's different clinical needs.
- Staff reported that staff retention was very good and there was no problem with sickness or recruitment.

Are outpatients services effective?

Not sufficient evidence to rate

There were a wide range of clinics, with most patients receiving their appointments within target times.

Evidence-based care and treatment

- Newark Hospital provided a range of outpatients, including ophthalmology, dermatology and endoscopy. No data were available to demonstrate the number of appointments had been carried out at Newark Hospital.
- Patient's needs were assessed, and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- The Royal College of Nursing and the Royal Marsden national guidelines were followed for clinical nursing procedures. Staff could access clinical guidelines, policies and procedures through the trust's intranet system.

Patient outcomes

- Data was accessible for the months of December 2013 and January 2014 for each clinical discipline's performance report. The data showed that most of the clinics were achieving the expected targets for non-admitted patients receiving an appointment within 18 weeks of referral.
- The customer services team, supported by hospital volunteers, surveyed patients and found that nearly all patients said they would be likely or extremely likely to recommend the hospital to family or friends.

Outpatients

Competent staff

- Staff in outpatients had received their yearly appraisals. There were systems in place to remind staff when appraisals and training were due. Pathology had achieved 95-100% appraisals at end of Dec 2013, for all areas within pathology.
- Staff kept up to date with trust news and development, via the trust's intranet.
- The manager had records of staff training and competencies; due dates for training and appraisals were advertised on staff notice boards.

Are outpatients services caring?

Good

Patients were treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink and transport arrangements. Emotional support was available from nursing staff.

Compassionate care

- Patients were able to feedback about their care, a letter was sent out to their homes and there were feedback sheets in waiting areas. Feedback was particularly complimentary about the ophthalmic services.
- Patients we spoke with told us that the staff were friendly, and Newark Hospital was a great resource for the community.
- The results from the feedback showed that patients were happy about the length of time they had to wait to be seen.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink and transport arrangements.
- The environment in the outpatient department allowed for confidential conversations.
- Chaperones were provided as required.

Patient understanding and involvement

- Patients we spoke with told us that they had the opportunity to ask questions during their appointments.

Emotional support

- Nurses were available in clinics to help with information and support.

Are outpatients services responsive?

Good

Most patients had access to outpatient services within times set by national guidelines. Telephone reminder systems were available to those patients who had mobile phones.

Patients did not get the opportunity to choose Newark Hospital in the 'choose and book' system provided to them by their GP, even though this was their preference and the services were available.

Staff aimed to deal with complaints as they occurred, to prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines.

Key responsive facts and figures

- Most patients were being seen as a follow-up within the times set in national standard guideline of 18 weeks.
- Data we received for the GUM clinic in December 2013 and January 2014 showed that all patients were offered appointments within 48 hours and 52% of patients accessed an appointment within 48 hours.
- Patients used the 'choose and book' system for GP referral for two week wait appointments. The trust saw around 800 of these patients a month. The trust met all of their targets for two week wait appointments in quarter 3.
- 95% of patients used the 'choose and book' system.
- Follow up appointments for six weeks were given to patients at reception; if no appointment was available in six weeks, the divisional team organised the appointment and informed patients by post. Where there was an increased demand for appointments, extra clinics were created to increase capacity.

Service planning and delivery to meet the needs of local people

- Letters were dictated at the time of the clinic and sent to the GP within one week of the outpatient clinic.

Outpatients

- Patients did not get the opportunity to choose Newark Hospital in the 'choose and book' system provided to them by their GP. The services were available at Newark, and patients told us that they wanted to receive the care at Newark Hospital.
- Telephone translation services were available for patients that could not understand English.
- There was a volunteer coffee shop in the outpatients' reception area, with a wide range of snacks, and hot and cold drinks.

Access and flow

- The trust had cancelled 4,362 appointments throughout all of their outpatient clinics between September 2013 and February 2014; 63% of these were due to lack of staff availability and 18% due to administrative error. These cancellations equated to around 3% of appointments during the time period.
- A consultancy had been employed to monitor waiting times in clinics; the study had not been completed, which meant that the trust did not have information about waiting times.
- New electronic notice boards designed to keep patients informed of waiting times were working well.

Meeting people's individual needs

- Patients received their appointment letters with information about the location of the hospital and the clinic.
- The trust monitored the number of patients that did not attend (DNA) clinics. The data available for December 2013 and January 2014 for Newark Hospital showed that 5% of patients did not show up for their first appointment, and 8% for their follow-up appointments. This meant that Newark Hospital was experiencing around the national average of patients that did not turn up for their appointments.
- Patients received a reminder by text alert to their mobile phones seven days before their appointment, with an opportunity to reply.
- Patients who did not use mobile phones could not receive reminders; however, the trust had identified this and were in the process of tendering for an interactive voice message service.
- Staff at the appointments call centre could cancel and change appointments. Staff told us that the current system was difficult to use and described it as 'clumsy'. There was a facility to place patients on a cancellation list. Staff expressed concern that the call centre did not have the facility to show how long patients had been waiting for their call to be answered, to allow other staff to step in to take calls at peak times.
- Patients paid the standard fee for car parking, which was £3 for up to four hours. The hospital had provided information on their website for patients who were on low income, who may be able to recover the costs of car parking through the Healthcare Travel Costs Scheme.
- There was a volunteer coffee shop in the main reception area, with a wide range of snacks, and hot and cold drinks.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints were dealt with by the outpatient manager who resolved the issues face-to-face or by telephone. Where complaints were not resolved, patients were directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.
- From September 2013 to February 2014, the trust received 103 complaints about all outpatient services; this related to 0.2% of all outpatient appointments. Of these, 20 complaints related to difficulty in getting appointments, and seven where people's appointments had been cancelled without their knowledge. 17 complaints related to the attitude of the staff, and 7 to missing notes.
- The trust had a target of responding to complainants within 40 days. Of the 103 complaints, 35 were responded to within the 40 working days; however, 29 had been responded to after 40 working days, and 39 remained open and unanswered. Five complaints had been re-opened. This meant that the trust had not met its target of responding to patients' complaints within 40 days. A satisfaction survey of complainants was being undertaken.

Outpatients

Are outpatients services well-led?

Requires improvement

Newark Hospital service provision was changing, staff said that they did not have a voice, and they had not been consulted about the changes. The new trust vision had not been embedded at the hospital.

Staff communication between Newark Hospital and King's Mill Hospital showed, at times, a lack of respect for each other. Staff culture within Newark Hospital was supportive.

Vision and strategy for this service

- The trust vision had been recently introduced, promoting quality for all, focusing on staff behaviours and quality of care. This had not been embedded, and most staff we spoke with were not aware of the vision.

Governance, risk management and quality measurement

- Monthly governance meetings were held within Newark Hospital, with representatives of staff from all departments.
- The trust had not ensured that policy and governance decisions about all outpatient services had impacted positively on the services delivered at Newark Hospital.
- Complaints, incidents, audits and quality improvement projects were discussed at monthly meetings.

Leadership of service

- There were many changes in the services provided by Newark Hospital taking place; staff said they had not been consulted and did not know the members of the trust board. Staff told us that they did not have a voice.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility.
- Newark Hospital had monthly meetings where all staff were invited to bring innovative ideas.
- Staff worked well together, and there was obvious respect between, not only the specialties, but across disciplines.
- Openness and honesty was the expectation for the department, and was encouraged at all levels.
- Staff felt supported locally; however, staff reported they were not made to feel welcome when attending training at King's Mill Hospital.
- Staff at Newark Hospital reported that they did not always feel respected as, at times, communication from King's Mill Hospital staff was dismissive and, at times, derogatory.

Outstanding practice and areas for improvement

Outstanding practice

Surgery

Systems and processes in place in the pre-operative assessment department. The department was very efficient and utilised their skill mix.

Overall, services for patients we very caring

Areas for improvement

Action the hospital MUST take to improve

MIU

Regulation 9

The provider had not "reflected where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment".

Regulation 9

Trauma protocols, EoL guidance, WHO checklists

Regulation 10

- The provider had not made changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to – "(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and
- (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies"

Regulation 10 (2) (c) (i) (ii)

Regulation 22

The provider "must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity".

Regulation 22