

Mid Staffordshire NHS Foundation Trust

Stafford Hospital and Cannock Chase Hospital

Quality Report

Stafford Hospital

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The key question we were asked to consider whether Mid Staffordshire Hospital NHS Foundation Trust (MSFT) is currently providing safe care and whether safety was likely to be sustainable in the future. We were aware that the planned date for the dissolution of MSFT and transfer of responsibility for services to University Hospital of North Staffordshire NHS Trust (UHNS) and Royal Wolverhampton NHS Trust (RWT) is 1 November 2014. We therefore considered whether safe provision of services was likely to be sustainable over the next four months and beyond that over winter 2014/15.

Our approach

To undertake this task within a very short timescale we modified our new approach to inspection of acute hospitals. We concentrated particularly on the first of CQC's five key questions i.e. Safety. Within this we looked very closely at staffing levels for nurses, doctors and allied health professionals in key clinical services and the approaches that Trust Special Administrators and Mid Staffordshire Hospital NHS Foundation Trust has made to recruit and retain staff. We also looked at the impact of any deficiencies in staffing levels on the quality of care being delivered by staff at MSFT. Finally we considered the leadership of services at MSFT.

During the pre-inspection phase we looked at the report from the Trust Special Administrators (TSAs) regarding future configuration of services currently provided at MSFT. These recommendations have been accepted by the Secretary of State for Health and we were not asked to reopen the debate on these recommendations. Rather, the report provided us with the agreed direction of travel for different clinical services. We are also aware that a further review into the configuration of maternity services is being commissioned. We reviewed the safety and sustainability of services at this trust in this context.

We were given access to the minutes of the Sustaining Services Board, chaired by the TSA representative, which brings together leaders of the local health economy around MSFT and to a copy of the due diligence report commissioned by the Board of UHNS. The Chief Executive of MSFT and her staff were extremely helpful in providing detailed information on current and projected staffing levels and other recent performance management information for the trust.

In this process, we are not providing ratings on the trust as we normally would do. This is deliberate and reflects both the bespoke nature of the remit and the planned disaggregation of the trust in November.

An overview of our findings

The commitment of staff at all levels to the delivery of high quality care at MSFT was evident throughout the hospital. However, it is important also to recognise the degree of fatigue reported by staff. This relates both to the relentless external scrutiny focused on MSFT and from uncertainty about the future.

The trust is facing major difficulties in recruiting and retaining medical and nursing staff both because of the continuing uncertainties about the future and because of the previous poor reputation of the trust outside the local area. These factors are creating a large destabilising influence across the organisation.

The senior managers at MSFT, including the Chief Executive, are spending inordinate amounts of time ensuring that individual nursing shifts are adequately filled and that sufficient numbers of medical staff will be available for different services. To date they have just been able to do this, but the emphasis here is on the word just. This has resulted in a significant reliance on temporary medical and nursing staff, which has a resultant impact on permanent staff working in the relevant clinical areas. In addition, there is an almost complete dearth of formal medical service level clinical leadership at MSFT. While additional staff have been supplied by UHNS in some clinical areas, in other areas the movement of staff has been from MSFT to UHNS.

Summary of findings

Our inspection team members judged that safe care is currently being delivered in each of the clinical areas except for medical care which required some improvement. Staffing levels are only just adequate in some areas, particularly on the medical wards and of these, the winter escalation ward, (ward 11) was still open and gave the most cause for concern. Medical and nursing staffing pressures make this ward unsustainable.

The inspection team members were, however, much less assured about the sustainability of some services, even over the next four months. Should staffing levels fall by even one or two people in some key posts, services would become unsafe. The only option for handling such an eventuality identified to us either by the TSA or the trust management would be to reduce the bed base and almost certainly to restrict admissions to the hospital (unless flow through the hospital can be substantially improved). Indeed there have already been occasions when the West Midlands Ambulance Service has been asked to divert emergencies to UHNS or RWT. Undesirable as this is, this does indeed appear to be the only option available. The fragility of the provision of acute services cannot be overemphasised

The TSA and the trust management have proposed a reduction in the opening hours of A&E as a means of reducing the burden on acute services and thus maintaining safety. My inspection team had concerns about this approach. In particular they were concerned that it might not achieve the desired reduction in emergency admissions to the hospital and that it might render the junior doctor rotas unviable. This would at the very least need to be discussed with colleagues at Health Education England.

Looking beyond the planned date of transition in November 2014, inspection team members were unanimous in their view that services would be unsustainable should any degree of winter pressures arise. It is therefore imperative on safety grounds that the transition should not be delayed.

Transition

We were both surprised and very concerned that a clear transition plan has yet to be developed to ensure the safe transition of responsibility for clinical services to the agreed model of care over the next four months. This clearly requires full involvement of MSFT and other organisations in the wider health economy. Although the Sustaining Services Board has provided a useful forum for bringing together the relevant stakeholders it is not a decision making group and has no authority to take action. In addition the workforce at MSFT needs clarity as soon as possible about what is going to happen and when. The current uncertainty is contributing to the fatigue and fragility amongst staff. The transition plan should therefore include a commitment by the acquiring organisations to actively support medical and nursing staffing levels at Mid Staffs over the next four months so that services remain safe.

It is now imperative that a clear and timetabled transition plan should be developed and implemented without delay. This should set out the steps that will be taken to ensure services remain safe, effective, caring and responsive to patients' needs. Leadership responsibilities and accountabilities need to be clearly defined. This will require high level input and commitment from TSA/MSFT, UHNS and RWT and from CCGs and WMAS. No single organisation can achieve this on its own. High level oversight from Monitor and TDA, as the organisations which oversee the various providers will be essential.

Yours sincerely

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Judgement

There were enough staff to care for patients. There was a high use of agency and locum staff and this did increase pressure on permanent staff at times. There were systems to manage the risks of staff who did not work regularly at the department.

The department was well led at a local level. Staff were working cohesively to provide care and to improve services. There were systems in place to monitor the quality of care.

The pressures to manage patient flow through the hospital were impacting on the A&E's ability to move patients through the hospital. The lack of detailed communication about the transfer of services was causing pressure for staff and contributing to problems in recruiting and retaining staff.

Medical care

We considered that medical care services required some improvement for safety and was very fragile. There were vacancies in all areas we visited for both nursing and medical staff, with additional long term staff sickness and maternity leave evident. The use of locum, bank and agency staff had an impact on the continuity of care for patients. It was positive to see that identified care pathways with proformas for locum doctors to follow were available to provide guidance on best practice. However vacancies for senior doctors and nurses and their replacement by temporary staff provided concern for the supervision and support of junior doctors and nurses.

There was regular monitoring of key safety measures however the high use of temporary staff did not give assurance that all incidents were appropriately reported. We were not assured that the high staff turnover on some wards meant that appropriate lessons were learnt from complaints. Some medicines were not stored appropriately which may affect their effectiveness.

Patients received compassionate care and we saw that patients were treated with respect. There was regular monitoring of key safety measures, and ward areas were clean.

Surgery

Currently patients received safe, compassionate care. The ward managers ensured to the best of their ability,

Summary of findings

that the staff on duty were suitably skilled and competent. Staffing shortages had impacted on the day to day running of the wards and the ward managers were tasked with covering the 31% staff vacancies in surgery. The patients that we spoke with told us they had been shown respect, treated with dignity and had been well cared for. However, due to the increased use of agency staff and the increasing numbers of medical outliers within surgical beds, the challenge of meeting demand was increasing.

Monitoring systems were in place to promote patient safety and incident reporting was promoted although we were told that learning from incidents had not been widely cascaded. Adherence to the WHO checklist was embedded by staff carrying out surgery or interventional procedures. Safety checks of equipment were carried out in wards and theatre theatres and records were available. Elective patients were pre-assessed before admission and were admitted to the wards or the day unit. Discharge planning began reasonably early in the patient's pathway of care and there was a multidisciplinary approach.

Patients and relatives we spoke with gave us examples of the outstanding care they had received in the unit. Staff worked as a team and built up trusting and consistent relationships with patients and their relatives by working in an open, honest and supportive way. They worked hard at good communication by providing clear information and listening to people.

There was strong local leadership of the units. Openness and honesty was encouraged at all levels. The units were well covered by consultants and registrars and had good, flexible nursing, including senior nurses and stable bank cover.

Quality outcomes were measured, staff were encouraged and supported to report incidents and learning from incidents was passed on through regular staff meetings.

Good care is provided for women and babies. We were told that women were satisfied with the care they had received and this was supported by evidence in local and national surveys. The staff reported that the department was a friendly and supportive environment to work in but that it could become busy at times.

Critical care

Maternity and gynaecology

Summary of findings

There were processes in place for reporting, responding to and learning from incidents although more could be done to encourage staff to take part in generalised learning opportunities.

Staff reported uncertainties about the future which impacted on morale but that they were following a business as usual model.

Outpatients and diagnostic imaging

The radiology service of Mid Staffordshire hospital was providing a safe service at the time of our inspection. Radiologist staffing levels have reduced significantly during the past few months and are set to reduce further during August and September 2014. However, the service has put in place a strategy to address current and future radiology staffing levels making the service sustainable until November 2014.

Stafford Hospital and Cannock Chase Hospital

Detailed findings

Services we looked at

Urgent and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Outpatients and diagnostic imaging

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Detailed findings

Background to Stafford Hospital and Cannock Chase Hospital

Much has been written about this trust in recent years. This is a different organisation to that from 2009 and the challenges it is facing are exceptional.

Mid Staffordshire Hospital NHS Foundation Trust (MSFT) serves the population of South Staffordshire. It is based on two sites, Stafford Hospital and Cannock Chase Hospital. There are approximately 350 beds, last year the trust had approximately 28,000 inpatients, there were 1800 births and over 45,000 people came to Accident and Emergency.

In 2013 the trust was declared clinically and financially unviable and the Trust Special Administrators (TSA) were appointed by Parliament in April 2013. In addition to taking on accountability for the day to day running of the Trust, the administrators were required to develop a plan for ensuring that clinically and financially sustainable services can be delivered for the local population currently served by the trust. The plan recommended that the trust be dissolved and responsibility for Cannock

Chase hospital should be given to Royal Wolverhampton Hospital NHS Trust (RWT) and Stafford Hospital to University Hospitals of North Staffordshire NHS Trust (UHNS).

In January 2014, Monitor confirmed approval of the proposed dissolution of the Trust and passed the report to the Secretary of State for consideration, who approved the principal recommendation that the trust should be dissolved. The date for dissolution of the trust is currently set for 1 November 2014 and services will transfer to the new providers from that date.

This inspection has been requested by Monitor, the Trust Development Agency (TDA) (as both UHNS and RWT are not foundation trusts) and the TSA. All of these agencies have expressed serious concerns about the sustainability of safe staffing levels at MSFT and they have jointly asked for an independent review by CQC. We have carried out this focused inspection in response to this request.

Our inspection team

Our inspection team was led by:

Chair: Dr Andy Welch, Medical Director and Consultant ENT Surgeon, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team of 28 included CQC inspectors and a variety of specialists: consultant radiologist and radiography

manager, consultant surgeon, ex divisional surgery manager, specialist registrar in anaesthetics and intensive care medicine, emergency department matron, emergency medicine consultant, midwife and supervisor of midwives, consultant physician, respiratory specialist registrar, deputy director of nursing, chief operating officer, director of nursing and two experts by experience.

How we carried out this inspection

As this was a focused inspection we did not cover all of the five key questions across all core services. The main focus of the inspection was on the safety of current staffing levels in acute services and on the likelihood of these being sustainable over coming months.

Due to the specific focused nature of the inspection, we have relied on the trust to provide us with key performance metrics and we have reviewed specific

documents from the TSA, local Sustaining Services Board, along with minutes from the Transition Board and other key documents. Additionally, we have engaged with key stakeholders from the local community and representatives of local health organisations.

Detailed findings

We held a listening event, in Stafford, on 30 June 2014, when over 100 people shared their views and experiences of Stafford Hospital. Some people who were unable to attend the listening events shared their experiences in other ways, including via letter, email or telephone.

We carried out an announced inspection visit on 1 and 2 July 2014. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative

and clerical staff, theatre staff, physiotherapists, occupational therapists, pharmacists, radiographers, domestic staff and porters. We also spoke with staff individually as requested.

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

Detailed findings

Facts and data about Stafford Hospital and Cannock Chase Hospital

- The trust provides healthcare for people in Stafford, Cannock, Rugeley and the surrounding areas, serving a population of over a quarter of a million people.
- Last year it treated over 28,000 inpatients and over 29,000 day cases
- There were over 294,000 out-patient attendances and over 45,000 accident and emergency attendances
- There are 2,418 staff employed over two sites at Stafford and Cannock Chase
- The trust has an annual income of approximately £155 million
- The trust has been in administration since 2013 and is run by the Trust Special Administrators (TSA).

Urgent and emergency services

Information about the service

The A&E department was originally open 24 hours a day however since 1 December 2011 it has closed overnight between 22.00 and 08.00. The decision to reduce the opening hours had been taken to reduce the number of admissions to the trust as there was a shortage of senior clinical decision makers to ensure the safety of inpatients. Senior clinical and management staff told us that this had worked initially but now the unit was seeing and admitting the same number of patients prior to the closure within the compressed hours. During 2013/2014 there were 46,488 patients who attended the department.

In the department, there are four resuscitation bays, including one for children, eight major injuries beds ('majors'), six initial assessment and treatment bays (C corridor), seven minor injuries ('minors') and a newly opened Seated Assessment and Review Area (SARA).

We spoke with seven patients and relatives visiting the unit and 16 staff of different grades. These included nursing and medical staff, therapists, receptionists, managers, support staff and members of ambulance crews. We observed care and treatment and looked at records. Before the inspection, we reviewed performance information about the hospital.

Summary of findings

There were enough staff to care for patients. There was a high use of agency and locum staff and this did increase pressure on permanent staff at times. There were systems to manage the risks of staff who did not work regularly at the department.

The department was well led at a local level. Staff were working cohesively to provide care and to improve services. There were systems in place to monitor the quality of care.

The pressures to manage patient flow through the hospital were impacting on the A&E's ability to move patients through the hospital. The lack of detailed communication about the transfer of services was causing pressure for staff and contributing to problems in recruiting and retaining staff.

Urgent and emergency services

Are urgent and emergency services safe?

The department was full and struggling with capacity due to the lack of beds in the hospital for patients to be admitted into. Although the department closed to admissions at 22.00, it was usual for the department to remain open overnight to care for patients for whom there was no bed available in the admitting speciality. There may be as many as 14 'beds spaces' available.

There was a high usage of temporary staff within the service. There were systems in place to manage the risks of staff who did not regularly work at the department. The high usage of agency staff put pressure on the permanent staff and doctors were regularly providing cover when shifts could not be filled.

Has care been safe in the immediate past?

- There were a series of audits in place to ensure that safety standards were maintained. Audits identified a target level of 95% compliance and a warning level of 90%. The results for controlled drugs were 83% in April 2014: 93% in May 2014 and 90% in June 2014 against the standards within the audit.
- Audits of resuscitation trolleys in the department were also undertaken to ensure that daily checks were undertaken. The results were:
 - Resuscitation area: April 100%, May 100%, June 93%
 - Majors area: April 93%, May 100%, June 93%
 - Minors area: April 96%, May 90%, June 96%
 - Paediatric trolley: April 93%, May 96%, June 96%
- There were also audits to check that care bundles were being followed which demonstrated that performance across the department was on target.
- Staff we spoke with knew how to report incidents. There had been four serious incidents reported since May 2013: one was a fire in the department and three related to clinical care. Staff knew how to report incidents and told us that they would be told about learning from them at handovers and monthly staff meetings.
- There was evidence in the senior sister meeting minutes that information was shared and cascaded down to staff regarding learning from audits. Staff told us and this was confirmed by minutes of staff meetings that learning

from incidents was shared at handovers and at staff meetings. The meetings were minuted and displayed in the staff room for staff who were not able to attend the meeting.

- The department was in the process of setting up a safety panel to challenge practice and review incidents, produce action plans and disseminate learning. Minutes showed this had been discussed at the June meeting for senior sisters.

Is care safe now?

Nurse staffing levels and skill mix

- On 28 May 2014 there were 12.3 whole time equivalent (WTE) nursing vacancies, out of a 40.3 WTE establishment. To maintain safe care the department had identified a 'tipping point' that 50% of nursing staff and at least two Registered Nurses on each shift must be substantive trust staff. If staffing levels fell below this, then this would be escalated to the site management team.
- On our inspection senior staff told us that vacancies had recently been recruited into. A rotation programme with supporting education programme had been put in place which had proved effective at attracting staff. The staff had not yet started while pre-employment checks were completed.
- To help support safe staffing in the department and facilitate integration of the department into UHNS, six staff had been seconded from UHNS A&E department, including a matron and Band 6 and 7s. Not all staff had stayed: the matron had taken on another role at UHNS and two staff had decided to return to UHNS. Three UHNS staff were currently working in the department.
- There was a draft workforce model which needed further work to ensure that the rota was covered. There was a tool for monitoring staffing levels a week in advance which identified where there were unfilled shifts. These shifts would then be filled by bank or agency staff.
- Since January 2014, a total of 12894 hours had been covered by agency and bank staff. In June, the number of hours worked by bank/agency registered nurses was a total of 217.5 hours, the lowest figure since January 2014.
- Staff told us that there were a number of agency staff with A&E experience who worked regularly at the

Urgent and emergency services

department. These included former departmental staff and staff from neighbouring A&E departments. When we spoke with agency nurses during our inspection, they all had A&E experience.

- Staff described a number of actions in place to mitigate the risks of staff who were not permanently employed, including:
 - unfilled shifts were offered to bank staff and preferred agencies first, with staff known to the department being requested
 - senior staff told us that they booked staff up to six weeks in advance
 - staff induction
 - agency staff could not undertake certain procedures such as removal of foreign bodies, cannulation, venepuncture
 - agency staff were supervised by substantive staff or staff who were familiar with the department
 - agency staff were not allowed to work unsupervised in high risk areas
- The department looked after adults and children. The Royal College of Paediatrics and Child Health Standards for Children and Young People in Emergency Care Settings 2012 state that Sufficient RN (Children) nurses should be employed to provide one per shift in emergency departments receiving children. As there were no children's nurses in the department, arrangements were in place for staff from the paediatric department to attend when necessary. Staff said this arrangement worked well and a children's nurse and paediatric registrar would attend on request.

Learning

- The department had previously been issued with improvement notices from the Health and Safety Executive (HSE) which required action to be taken to improve how information was handed over, care of patients at risk of falls, and documentation. The department had taken a number of actions to address the shortfalls:
 - The appointment of a lead nurse to lead the improvements

- Introduction of comprehensive new procedures for sharing information, the identification and care of patients at risk of falls and standards of documentation.

- A system to ensure permanent and agency staff were aware of and implementing the procedures

- A letter was sent to all staff on April 14th which asked staff to read the new procedures and sign to show they understood and would adhere to the new procedures. Initially this was to substantive staff (those who were employed by Mid Staffs). As the department employed a large number of agency staff, they too had been asked to read and implement procedures and sign to confirm.

- An audit system to monitor compliance with new procedures

- A review of the records for four agency nurses who were working on the days of inspection and records showed that they had all read the policies. Four sets of patient notes were reviewed and all contained an assessment of falls risk. One of the patients was judged at high risk of falls and the policy had been followed: a care plan was in place, a yellow triangle was on the front of the notes to alert staff to the high risk of falls, and the patient had their call bell and cot sides in place.
- We observed the handover of this patient by an agency nurse to the admitting ward: a Situation, Background, Actions, Recommendations (SBAR) form had been completed and this form was used to ensure a thorough handover which highlighted patient needs and risks.
- Adherence to the policy was checked internally via audit. An audit by an external consultant had taken place the day before our inspection: the results were not yet available. Verbal feedback to the lead nurse was good with the only area for improvement being the need to ensure the name of the person receiving the handover was recorded.

Medical staffing levels and skill mix

- There were six WTE consultant posts, covered by seven staff, three of whom were locums. All shifts had consultant cover.
- The clinical lead for the department was a consultant from UHNS who was also the clinical lead for A&E at UHNS. This consultant was working two clinical days a

Urgent and emergency services

week at Stafford. All the staff we spoke with commented on the positive effect that this appointment had for the department. Another consultant from UHNS was also working at the department.

- The rota for consultants should have meant consultants worked one weekend in six but currently they were working approximately one in three to maintain consultant cover, which relied on the consultants' goodwill to cover the gaps.
- During our visit, there were weekend shifts which were not yet covered for middle grade doctors however senior staff within the medical staffing department were not concerned as they said this was usual and they were confident they would be able to cover with staff who were familiar with the department.
- Middle grade staffing was currently stable as there were long term middle grade locums who had been in post several years on six month renewable contracts.
- Staff told us recruiting to permanent roles was difficult due to the uncertainty surrounding the trust's current situation of being taken over by neighbouring trusts. There had been poor responses to advertised posts. Attempts to recruit overseas for middle grade doctors had not been successful.
- There were seven doctors in training at the department: five second year foundation doctors (FY2s) and two GP vocational trainees.

What is the impact of staffing on caring and responsiveness?

- On the first day of our visit, there were 14 patients who had spent the night in A&E because there were no beds available in the hospital. Senior trust staff said that this was because of an unprecedented surge in patients attending A&E who required admission the day before our inspection. Figures provided by NHS England showed that the figure was similar for the previous three Mondays.
- Although the department accepted no patients after 22.00, two nurses were allocated to work overnight as patients' staying overnight was a usual occurrence: staff told us it was very rare when there were no patients staying overnight. If there were no patients, staff were redeployed to other wards in the hospital.
- Staff from the chief operating officer's team with A&E experience were working in the department, along with

practice development staff to support nursing staff.

Although every bay in resuscitation and majors was full, the department was calm and the shift was being led by the nurse in charge very effectively.

- There were enough nursing staff to meet the needs of the patients in the department. All patients except one had been transferred onto beds overnight to promote comfort. Patients told us they were very happy with the care they received.
- Records showed that patients' vital signs had been monitored appropriately. Pain had been monitored and analgesia given where required. Risk assessments had been undertaken and actions taken to reduce identified risks.
- Long waiting times in A&E departments (often experienced by those awaiting admission and hence ill patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness. NHS England set an operational standard of 95% for patients being seen and discharged within 4 hours of attending the department.
- The department regularly breached this target. For the period April-June 2014, the trust had achieved a performance of 85.6%. On the first day of our visit there had been 125 attendees. When we left the department at 22.30, there had been 25 breaches of the four hour target. There were still 30 patients in the department which meant there was a potential for further breaches.
- NHS England set a target that no patients should wait more than 12 hours on a trolley in an A&E department and CCGs are empowered to take action (fines) against providers that breach this condition. All A&E departments must report when patients have been waiting for over 12 hours. There was a procedure for staff to follow when patients were approaching the 12 hour wait.
- For the period April-June 2014, the trust had reported no breaches of the 12 hour wait.
- The department was not using the time of admission to the department as the start of the 12 hour period. The time was taken from when the decision to admit was made by the admitting speciality, which at times was a considerable length of time after the admission to A&E.
- Between April 2014 and June 2014, the department has seen 12462 attendees with 3517 being admitted, a conversion rate of 28.22%. Of the 12462 attendees, 944 patients had been classified by the trust as overnight

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stayers in A&E: the criteria being still in A&E after midnight which meant that the department was normally staying open as there were no available beds in the hospital for patients to be admitted into.

- Staff we spoke with told us that there was usually an influx of patients in the last hour. When we visited at 21.00, the minor's area had only 1 patient. By 22.00 it was full, with patients in the waiting room.
- The Friends and Family Test for A&E for May 2014 had a total response rate of 31% with 682 responses, 434 of which said they were extremely likely to recommend the service.
- On our visit a person told us of a complaint they had made at a recent attendance about long waiting times. They were happy with the care their family member was receiving during their current attendance at the department.
- We spoke with ambulance staff who were bringing patients to the department. They were very positive about the care at the department. They said staff were very caring and responsive to patients they brought in.
- There was a longstanding divert policy in place which had been agreed when the opening hours of the department had been reduced in December 2011. This outlined the arrangements for when the department was closed. In addition there were escalation arrangements in place which would be implemented if the department was unable to accept patients. Staff were able to describe the procedures and when they would escalate to ensure that patient levels could be managed safely.
- In order to improve patient flow through the department, an area which had previously been used for occupational therapy assessment had been changed to the Seated Assessment and Review Area (SARA). A standard operating procedure and criteria for suitable patients was in place. This system had only been in place for a week and therefore it was too early to assess the impact.

Is care in the future likely to be safe?

- If the current opening hours for the department are maintained, we considered it to be safe and sustainable. Whilst recruiting and retaining staffing for both nursing and medical staff were challenging there were plans in place to address the issues. Agency staff were used, many of whom worked regularly at the department and were familiar with the trust's systems.

- Any reduction in the hours that the A&E is open might compromise the sustainability and safety of the service, the reasons for which are outlined below.

What alternatives to staffing on site have been considered and/or implemented?

Risks if further restriction of opening hours

- There had been a reduction in the number of people attending the service following the decision to close overnight in 2011: this had not been sustained and the department was now seeing the same number of patients in a compressed number of hours.
- Further reduction of hours could lead to surges of patients in the shortened hours. During our visit we saw that the department filled during the last hour of opening. Staff reported that there were often queues outside the department when it opened in the morning.
- Patient surges would lead to a decrease in flow through the department and a probable worsening of performance against hourly and four hourly targets.
- Any reduction in hours could lead to a fall in morale which was currently recovering following the support from UHNS and recruitment of staff. There is a risk that further recruitment and staff retention may suffer with any reduction in opening hours.
- A reduction in opening hours may mean that doctors in training may not get sufficient experience for the post to be considered a suitable training experience which would also impact on other departments in the hospital.
- The potential surges of patients could also increase pressure across the hospital, which is already unable to manage patient flow. The winter pressure ward remains open and the ambulatory care ward is operating as a ward.
- There is a risk that some patients could delay attendance at the department rather than attending an alternative A&E department and therefore be sicker when they arrived at the department. Aside from the potential of risk to patient safety, this would also increase the pressure on the department and may lead to an increased length of stay which could impact negatively on the trust's performance.
- Failure to perform effectively against target would put the reputation of the trust at risk.

Risks at a regional level

Urgent and emergency services

- There is a risk of increased workload for social services if services at Stafford A&E are further reduced as more patients would be admitted to out of area hospitals.
- Nursing and ambulance staff told us of occasions where patients had waited for Stafford A&E to open rather than seeking assistance at the onset of symptoms. This puts patients at risk.
- Ambulance services reported a poor performance in Stafford re their own response time targets. This would further deteriorate if they had to travel further to access A&E services as the time taken for call outs when the department was closed would increase. This would also impact financially on the ambulance service as costs for answering calls would be greater when Stafford A&E was shut.
- There were also unknown risks for the local health economy including how the diversion of patients would impact on neighbouring hospital's performances.

Are urgent and emergency services well-led?

The department was well led at a local level. Staff were working cohesively to provide care and to improve services. There were systems in place to monitor the quality of care. There had been a lack of clarity in the amount of support via the supply of nursing and medical staff that UHNS were providing. This was being addressed locally with a seconded UHNS nurse now leading integration for staff from UHNS.

The pressures to manage patient flow through the hospital were impacting on the A&E's ability to move patients through the hospital. The lack of detailed communication about the transfer of services was causing pressure for staff and contributing to problems in recruiting and retaining staff.

Governance, risk management and quality measurement

- The A&E department sat within the medical division and participated in monthly governance meetings where audits, incidents and service performance measures were discussed. The speciality manager attended these meetings and cascaded the information to the department.

- Serious incident meetings were taking place in the medical division, which were open to all staff. Staff from A&E had not yet attended these, but were aware of them and viewed them as a positive way of improving care.
- Results from the quality dashboard were available for staff but not the public.

Leadership of service

- The appointment of the clinical director from UHNS was viewed as a positive appointment by staff. However, they were on sabbatical leave at the time of our inspection although cover was being provided.
- Weekly medical staff meetings were taking place.
- Nurse leadership of shifts were effective, and staff felt supported within the department. There were monthly staff meetings for nursing staff which were minuted and cascaded. There were also minuted monthly staff meetings for senior sisters.
- A senior nurse from UHNS was leading on integration of staff coming to the department from UHNS to help improve the process but they have since returned to UHNS to take up a different post.
- Some staff we spoke with felt that there was a lack of visible presence of the senior leadership team at the trust. The appearance of senior management in the department was associated with times when services were stretched.

Culture within the service

- Some staff told us that they had felt under considerable work pressure, particularly when there were high levels of temporary staff working.
- The difficulties in patient flow also contributed to the pressure staff in the department felt.
- Senior nurses were finding it increasing challenging to balance clinical duties with time for management and leadership duties due to pressure on the department.
- The matron told us that the department tried to ensure staff could attend off site training but this sometimes had to be cancelled if staff were needed in the department.

Public and staff engagement

- Information about the integration of services and placing of nursing and medical staffing had not been clearly communicated to staff in the department. Originally there were to be six senior nurses, including a matron, from UHNS supporting the department. The

Urgent and emergency services

matron had taken up another appointment in UHNS and this had not been communicated to staff in the department in a timely way. Only three of the six nurses were still at the department.

- There had been poor communication about the integration of services and the supply of staff from UHNS. The lack of clarity about how the service would look in the future was contributing to the ability to attract and retain staff. Recently nursing vacancies had been recruited to following concerted efforts and the offer of a rotation within the department and educational support.
- Medical recruitment continued to be problematic. The delay in the final date for transfer of services was also adding to the concerns felt by staff.
- Patients we spoke with were very happy about the care they received in the department and were very anxious about having to travel to other departments. A number of nursing and ambulance staff told us of occasions when patients had arrived at the department after waiting to contact emergency services as they had wanted to come to Stafford for care and treatment and not neighbouring trusts. One of the concerns was the long distance to travel to other hospitals with many people reliant on public transport.

Medical care (including older people's care)

Information about the service

The trust provides inpatient medical services at Stafford Hospital and Cannock Chase Hospital. At Stafford Hospital there were eight ward areas, an acute medical assessment unit, an ambulatory assessment unit, and two discharge lounges (one for female patients and one for male patients). The discharge lounges accommodated both medical and surgical patients. The medical division had 129 beds with an additional 27 beds which could be used during increased demand. There were at total of 151 beds in use at the time of our visit. There was one medical ward at Cannock Chase Hospital, Fair Oak ward which had 27 beds.

We visited the following wards: 1, 2, 10, 11, 12, the acute medical assessment unit (AMU); the ambulatory assessment unit which had six beds was being used being for patients overnight, the cohort ward (used for patients who had an infection and needed to be cared for in a side room), the acute coronary care unit (CCU) specialising in caring for people with cardiac conditions; the discharge lounges. At Cannock Chase Hospital we visited Fair Oak ward.

We spoke with over 63 staff which included different grades of nurses, doctors, therapists, administrators, porters and housekeepers. We spoke with 22 patients and six relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

Summary of findings

We considered that medical care services required some improvement for safety and was very fragile. There were vacancies in all areas we visited for both nursing and medical staff, with additional long term staff sickness and maternity leave evident. The use of locum, bank and agency staff had an impact on the continuity of care for patients. It was positive to see that identified care pathways with proformas for locum doctors to follow were available to provide guidance on best practice. However vacancies for senior doctors and nurses and their replacement by temporary staff provided concern for the supervision and support of junior doctors and nurses.

There was regular monitoring of key safety measures however the high use of temporary staff did not give assurance that all incidents were appropriately reported. We were not assured that the high staff turnover on some wards meant that appropriate lessons were learnt from complaints. Some medicines were not stored appropriately which may affect their effectiveness.

Patients received compassionate care and we saw that patients were treated with respect. There was regular monitoring of key safety measures, and ward areas were clean.

Medical care (including older people's care)

Are medical care services safe?

The use of locum, bank and agency staff had an impact on the continuity of care for patients. It was positive to see that identified care pathways with proformas for locum doctors to follow were available to provide guidance on best practice. However vacancies for senior doctors and nurses and their replacement by temporary staff provided concern for the supervision and support of junior doctors and nurses.

There was regular monitoring of key safety measures however the high use of temporary staff did not give assurance that all incidents were reported or were reported in a timely fashion. Some medicines were not stored appropriately which may affect their effectiveness.

We had particular concerns around the fragility of Ward 11 specifically around the staffing levels and the sustainability of the service model. This was a winter escalation ward (opened across the winter to ease the pressures on beds) which had never subsequently closed.

Has care been safe in the immediate past?

Safety Thermometer

- NHS Safety Thermometer safety indicator information was monitored regularly and there were monthly reports available of the performance of each ward. Information about the ward performance against these safety indicators were either not displayed within most wards or were displayed in a format that they could not be easily read, only Fair Oak ward had information displayed in a format that could be understood by patients and their representatives.
- The trust's performance between March 2013 and March 2014 for harm free care to patients was better than the average for organisations in England.
- Between March and November 2013 the trust had mostly performed well when compared to the other organisation in England for falls with harm. However since November 2013 the trust had performed worse than the average for falls with harm.
- The trust's performance for catheter and urinary tract infections (UTIs) was worse than average for organisations in England. Performance for pressure ulcers for patients was variable throughout the year although the trust's average annual performance was slightly worse than national performance.

Incidents, reporting and learning

- For the period 1 June 2013 to 31 May 2014 there had been 45 serious incidents for the medical division. These had been or were being investigated and actions taken to prevent reoccurrence.
- There have been nine clostridium difficile (C. difficile) and 2 cases of MRSA reported between 1 June 2013 and 31 May 2014. Our intelligent monitoring showed that whilst this was higher than expected, it was not sufficiently raised to cause concern.
- All the staff we spoke with said they were aware of how to report incidents. Although bank staff were able to report incidents this was not the situation for agency staff who needed permanent staff to report the incident on their behalf. This was because the reporting system was electronic and temporary staff do not have access details for the hospital's system. Staff also told us that the process was time consuming which was problematic particularly when they were busy. Two ward sisters whom we spoke with agreed that this was a problem and that it was frequently them who would report the incident. Staff told us they received feedback from the incident reported but were not confident that lessons learned from incidents were widely shared.
- Staff were not aware of previous complaints made and actions that were in place to ensure that when needed lessons were learnt, particularly on ward 11

Is care safe now?

Nursing staff

- There were required staffing levels set out for each ward. Information boards on each ward seen did not clearly identify the minimum/ required staffing levels but recorded the names of staff on each shift.
- Staffing levels were being managed on a shift by shift basis. For example, on the morning of our inspection, we noticed that the staff information board on ward 11 showed an agency nurse had been booked (but not confirmed) for the afternoon shift. An agency nurse was later confirmed and the nurse's name recorded on the board. Patients on wards 2 and 11 did tell us that sometimes agency nurses did not arrive at night.
- A number of triggers, known as "tipping points" had been identified on the wards, this is the point at which the service would be considered unsafe. These triggers

Medical care (including older people's care)

included a permanent MSFT (or UHNS) nurse in charge of a ward and no more than 50% agency nurses on duty on shift each ward. The triggers are described elsewhere in this report in detail, however, they are locally derived.

- When one of these triggers was reached staff alerted matrons, senior managers or the site coordinator who then tried to get additional staff but this did not always happen.
- There was a high vacancy rate and particularly vacancies for experienced registered nurses who were able to take charge of a ward. The trust has higher than average sickness rates for all staff which compounds the vacancy issue. Senior staff told us that staff recruitment was ongoing although it had become increasingly difficult to recruit staff due to the high level of scrutiny the trust is subjected to and its previous poor reputation. Shifts were filled whenever possible, with regular bank, agency staff and with UHNS nurses.
- The majority of wards said that the numbers of required staff usually met patient's needs. Staff also confirmed that if patients required one to one care this would be assessed and usually met which we saw during our inspection. MSFT staff identified difficulties of working with staff who were unfamiliar with the ward.
- The sister on Fair Oak ward at Cannock said that there were insufficient staff on late duty due to the number of staff required to escort patients to outpatient appointments that were frequently at other hospitals. Since the 16 June Fair Oak staff were required to escort patients off the ward for 39 hours during which time they were not available to provide care for patients on the ward.
- The Parkinson's Lead Nurse left the trust in March 2014. The trust is currently unable to recruit to the post and/or get additional support from nearby Trusts to ensure that patients receive appropriate care from a specialist nurse.

Medical staffing

- The trust should have 43 medical consultants, however at the time of our inspection there were 13 consultant vacancies within the medical and elderly care speciality. The majority of vacancies were filled by locum consultants and support from UHNS consultants although senior staff told us that 7% of vacancies remained uncovered. Of the 11 medical specialities, four had their full establishment for consultants.

- Acute medicine, cardiology, gastroenterology, neurology and elderly care were the specialties with the most risks and challenges for patient safety.
- We were told that elderly care had had 11 different locum consultants since January 2014. This was partly due to the trust not wanting to continue with the contract because of the poor quality of the doctor but sometimes because they did not want to stay.
- One senior doctor told us: "There is no 'elasticity' and they were working at full stretch". Senior medical staff told us that the current situation with the number of consultant's vacancies put patients at increased risk.
- We were told that an elderly care consultant from The Royal Wolverhampton Trust would be providing cover for Fair Oak ward from the week commencing 7 July 2014.
- Fair Oak ward had cover from a middle grade doctor out of hours and at the weekend.
- Consultants were present in the acute medical unit (AMU) 7 days a week. Ward rounds were undertaken daily. There were two physicians of the day (PODs) to ensure cover on the AMU and to attend to patients on the medical wards who needed to be seen by a consultant.
- There was one registrar, one middle grade doctor and one junior doctor to cover the medical inpatients during the evening and over the weekend (approximately 128 patients). Overnight there was at least one junior doctor and a middle grade doctor on call within the hospital. Staff also told us that they were well supported by the critical care outreach nurse practitioner who also acted as an advance nurse practitioner out of hours and reviewed deteriorating patients.
- The number of vacancies of senior doctors made the supervision and ongoing practice based training for junior doctors problematic.

Medicines

- Arrangements for medicines such as receipt, administration and storage were generally appropriate on the majority of wards.
- On Fair Oak ward we found that there were gaps on four of the five medication administration records (MAR) we looked at. We found that staff had not consistently signed to confirm that the medication had been administered or the reason why it had not been.

Medical care (including older people's care)

- We saw examples of medicines crossed out but the reason for this was not consistently recorded or the signature of the doctor. We showed the records to the ward sister who agreed that records were confusing and would address this.
- The medicines fridge temperature on Fair Oak had been above the required maximum temperature for more than a month. This meant that medicines had been stored outside safe temperatures and may not be effective for patients.
- When staff checked the medicines that were stored in the fridge the majority belonged to patients who had been discharged and should have been returned to them. The ward manager told us that medicine checks were no longer undertaken.
- On the Ward 2 the treatment room door was propped open. Needles and syringes were stored on open shelves in the room. The ward manager told us that they had been told to wedge the door open when they reported that the medication fridge temperature was higher than the temperature at which medicines should be safely stored at. Medicines being stored included antibiotics and essential heart medicines and as a result of the incorrect storage temperature these medicines may not be effective.

What is the impact of staffing on caring and responsiveness?

- Patients and relatives we spoke with mainly said that staff were caring and "did their best". Patients on ward 11 and 12 expressed their concern about staff continuity. One person said: "I go to ask them something about my relative but they say they don't know because they are bank or agency".
- We visited ward 11 and 12 at mealtimes and observed those patients who required assistance to eat their meal received it. It was positive that visitors could visit outside usual visiting hours to assist their relatives at mealtimes which we observed during our visit. We did note that during our time in the trust, many patients were self-caring. We noted that if the acuity of patients increased this would have an impact on the ability to meet these needs.
- Call bells were answered quickly on the wards we visited. We did observe one occasion where there was a delay of more than 7 minutes on one ward (Fair Oak) and

although three staff members were in the next bay none went to answer the call bell. Three patients said that there was a delay at night answering call bells due to staff shortages but said that staff did their best.

- Three relatives contacted us before our inspection and said that they felt that staff were not all caring and gave examples when they had found their relative was ignored and had not had their call bell or a drink available.
- Staff told us that there was sometimes a delay getting medical staff to review a patient or prescribe medication at the weekend or out of hours. One staff member told us about a patient who was in pain and required stronger pain relief. We were told that they had to go to accident and emergency to see the doctor and ensure that pain relief was prescribed and the patient waited more than four hours for their pain relief. We were told this was not an isolated incident.
- The skills and experience of temporary staff differed and this was having an impact on the continuity of care. For example, delays in treatment because staff were not aware of changes to a patient's treatment plan or familiar with community care arrangements for patients who were medically fit but were unable to return home.
- Ward 11 was designated for additional patients during the winter months sometimes known as 'winter pressures'. Ward 11 was open and had patients at the time of our inspection due to the increased patient numbers. This ward was staffed with UHNS nurses, bank and agency staff and staff from other wards. Patients and staff raised concerns about the use of locum staff which included staff whose first language was not English and the poor impact this had for patients who were elderly and may be living with dementia. We also found that another ward with a high vacancy rate and high staff turnover was ward 12.

Is care in the future likely to be safe?

- The ongoing loss of nursing staff will increase the risks to patients. The trust have also identified that they are finding it increasingly difficult to ensure that the trusts own key measures to ensure patient safety are met. For example, ensuring a nurse is in charge of each shift on the wards.
- Staff told us that they have had difficulties covering shifts and can only see the situation worsening.
- One senior nurse on the acute coronary care ward said that they are required to have one coronary care trained

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nurse on each shift, but this was becoming increasingly difficult. We were told that that staff frequently came in on their days off and annual leave and staff had worked a night after they had been on an early shift which put staff and patients at risk.

What alternatives to staffing on site have been considered and/or implemented?

- In February 20 Band 6 and above nurses from UHNS came to assist the trust for three months, however most of these nurses have now returned to UHNS and have not been replaced like for like.
- 15 beds were made available at the Royal Wolverhampton Hospitals to assist the trust.
- The trust was considering the closure of ward 11 to reduce capacity and the need for additional temporary staff.

Are medical care services well-led?

We found that some medical wards were well managed although the lack of continuity of management arrangements for some wards meant that leadership was inconsistent. In addition, the lack of so called 'charge nurses' (those of sufficient seniority and skills to be able to be in charge of a ward) meant that the trust had been reliant on UHNS to supply them with these nurses. As mentioned previously, although this had occurred in the short term, UHNS were finding it difficult to sustain this as a long term solution meaning leadership at ward level was affected.

From a medical point of view, many of the clinical directors had left, and doctors who remained were either locums or those not equipped with the necessary leadership or managerial skills to take on a leadership role. There was no perceived solution to this problem.

Both the lack of sustained nursing and medical leadership had both an impact on current patient care but also failed to ensure that required improvements were made.

Staff spoken to were also unclear as to the long term strategy for the medical wards at the trust, leading to uncertainty surrounding future employment prospects at the trust. This was further exacerbating the attrition rate of staff as those who were able to were looking elsewhere for posts with increased security.

Governance, risk management and quality measurement

- Structured monthly governance meetings were held within the division. Complaints, incidents, audits and service performance information were discussed and actions agreed.
- The division had quality dashboard for each service and ward areas this showed performances against quality and performance targets and these were presented monthly at the clinical governance meetings.
- The integrated medicine risk register highlighted risks across all the trust's medical departments, and actions in place to address concerns: for example, bed capacity.
- Staff were not confident that there was a robust system to ensure changes to practice were communicated to all staff within the division particularly during a time when there was a heavy reliance on temporary staff.
- Senior nursing staff said that they did not feel their concerns about quality and risk had been listened to although reported that this had recently changed with now weekly meetings with the Director of Nursing.

Leadership of service

- Matron visited the wards most days although not all staff said that their presence was helpful.
- We found that there were robust management arrangements on some wards such as AMU but the lack of continuity of management meant this was not universal across the medical division.
- Ward managers were struggling to cope with the pressures on the ward and ensuring that wards were appropriately staffed.
- Staff told us that they were constantly "firefighting" and "plugging the gaps" requiring them to focus on everyday problems rather than a strategic solution to increased bed capacity and the increasing challenges around medical and nursing staff.
- The matron also said that they were too involved with day to day matters to enable them to have a strategic focus. There was a general lack of strategic leadership and direction from senior managers to support ward managers within the division.
- We found that there was a lack of continuity of leadership arrangements on some wards (ward 11 and ward 12). Relatives on wards 11 and 12 reported a series of ward managers/ matrons since their relative had been a patient.

Medical care (including older people's care)

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients but recognised the challenges to ensure this continued.
- Public and staff engagement
- The use of patient information boards and availability of patients' leaflets and literature was variable although we saw good information available for patients on ward 2. The 'Forget Me Not' programme was well publicised but its delivery such as the use of available patient information forms required improvement. These are important due to the staff turnover on wards 11 and 12 in particular.
- There was no information displayed on any of the wards we visited about the Friends and Family test which asked people if they would recommend the ward to their friends and family.
- Staff we spoke with said that they often felt that changes they suggested were not listened to.

Surgery

Information about the service

The hospital had 59 surgical beds available at Stafford and 15 surgical beds at Cannock Hospital. There was a suite of nine theatres at the Stafford site and five theatres at Cannock.

The day and theatre admissions unit (DATAU) catered for patients admitted for planned surgical procedures and those requiring diagnostic/therapeutic intervention. The unit also accommodates some emergency cases, including gynaecology and orthopaedic trauma. In-patients were admitted, taken to theatre and then transferred to the appropriate ward for their recovery. Day patients returned to the day unit post-operatively until discharge was appropriate.

The surgical assessment unit (SAU) was open 24 hours a day and accepted referrals from GPs, clinics and A&E. They reviewed patients who required emergency surgical, orthopaedic or gynaecology care. Following the assessment process and review by a doctor, patients could be discharged from the unit.

At Stafford hospital we visited three adult surgical wards, the day unit, surgical assessment unit, the operating theatre suite, anaesthetics and the recovery area. At Cannock hospital we visited one ward, the pre-admission unit and the theatre suite.

We spoke with 17 patients and three relatives of people using the service. We spoke with 24 members of staff ranging from domestic support staff, student nurses, nurses of all grades, junior doctors and consultant surgeons. We met and spoke with some staff in focus groups. We looked at six patient's medical records, observed staff handovers and a bed capacity meeting. We followed the patient pathway from the admission lounge to ward, theatre and observed positive staff interaction with patients, relatives and between the multidisciplinary team.

Summary of findings

Currently patients received safe, compassionate care. The ward managers ensured to the best of their ability, that the staff on duty were suitably skilled and competent. Staffing shortages had impacted on the day to day running of the wards and the ward managers were tasked with covering the 31% staff vacancies in surgery. The patients that we spoke with told us they had been shown respect, treated with dignity and had been well cared for. However, due to the increased use of agency staff and the increasing numbers of medical outliers within surgical beds, the challenge of meeting demand was increasing.

Monitoring systems were in place to promote patient safety and incident reporting was promoted although we were told that learning from incidents had not been widely cascaded. Adherence to the WHO checklist was embedded by staff carrying out surgery or interventional procedures. Safety checks of equipment were carried out in wards and theatre theatres and records were available. Elective patients were pre-assessed before admission and were admitted to the wards or the day unit. Discharge planning began reasonably early in the patient's pathway of care and there was a multidisciplinary approach.

Surgery

Are surgery services safe?

We saw evidence that patients received safe care during their stay in hospital. The patient pathway for each patient began with safety pre-assessment checks prior to consent for the surgery being given. There was evidence of appropriate risk assessments being commenced and acted upon with appropriate prophylactic treatment or management such as in response to their risk of acquiring a venous thromboembolism (VTE) whilst an inpatient.

Staff told us that they were supported by the critical care outreach team should a patient deteriorate. The patient records we looked at adhered to professional standards of record keeping and were clear and concise.

The trust used the World Health Organisation (WHO) surgical safety checklist for interventional treatments undertaken in theatre and radiology. The use of the checklist was found to be normal practice.

We were told that although incident reporting was encouraged on the wards, most staff said this was a time consuming process which they generally completed at the end of a shift, in their own time. The staff felt that although incidents were reported the results were possibly not a true reflection of the overall situation. Only permanent staff had a log on code and password. This meant that agency staff and bank staff did not have access to the process, unless they were accompanied by a member of the ward staff.

Has care been safe in the immediate past?

- NHS Safety Thermometer safety indicator information was monitored regularly and there were monthly reports available of the performance of each ward.
- Currently the standards were maintained with most wards achieving their thresholds. In May 2014 SAU had not achieved their threshold in one area Ward six and seven had achieved their thresholds and ward eight had not met two of their thresholds – fluid balance audit had achieved 88% and there had been three falls reported.
- The trust did monitor the data collection to look for trends and themes.

Incident reporting

- Between 1 June 2013 and 31 May 2014 the trust reported 27 serious incidents.

- The trust recognised there had been an increase in falls incidents. A review of all incidents relating to falls had been planned to take place.
- It was also recognised that the 'Falls Group' meeting was poorly attended by the surgical wards, and the 'Falls Safe' project was going to be re launched to try and get the focus back.
- Ward staff told us that poor attendance at such meetings was due to the low staffing levels and their inability to release any staff.

Is care safe now?

- Staffing levels to provide safe care were met in most areas of surgery during the inspection. SAU reported one absence which was to be covered during the inspection.
- Staffing levels were displayed on each ward as 'predicted' and 'actual' numbers.
- Ward level safety measures were in place such as individual risk assessments and reduction of risk measures. Falls prevention items such as non-slip footwear and yellow triangle 'alert stickers' were in use.
- Trained 'falls champions' names were displayed on the ward notice boards. Champions were kept up to date on practices and updates relating to falls prevention and risk assessments.
- Comfort rounds were recorded on each ward from midday. This tool checked patients overall care including their pain control and nutritional needs.
- A member of staff demonstrated that care was monitored; a concern had been identified regarding a patient's fluid output, a further care plan had been introduced to monitor their well-being.
- Matron and ward managers carried out spot checks on documentation and comfort rounds which formed part of Nursing Quality Assessment System (NQAS). NQAS included the results of the safety thermometer, looking at correlated trends and themes which were reported back to the corporate nursing team.
- The lack of substantive staff and over-reliance on bank and agency staffing was recorded on the risk register.
- There was a recognised inability to recruit substantive nursing and medical staff in surgical specialties due to the uncertainty of the future. This issue was noted on the risk register.
- There were 5.5 consultant surgeons participating in the general surgery on call rota, 3 of which were locums.

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This meant that the consultants were undertaking a 1:5 on call which was in breach of the national minimum recommendations of 1:6. A locum consultant had been appointed to support the on call rotas.

- Middle grade doctors were on a seven day rota.
- There were eight SHO's on a seven day rota.
- The junior doctors told us that it was a fairly quiet job in comparison to other jobs. They had regular protected teaching and they were generally happy in their jobs.
- We were told that consultants were called for advice overnight but were rarely required to attend.
- Active recruitment continued both internally and on NHS Jobs website.
- A recruitment day was held on 30 May which attracted 37 potential staff members, both qualified and unqualified, with a number of staff interviewed and recruited on the day.
- Not all recruitment exercises were proving successful.
- The trust's vacancy rate among nurses remains challenging, and the recent departure of nurses who came to support the opening of the escalation ward for winter pressures has resulted in a slight increase in vacancies and further concern around the stability of nurse staffing levels.
- Advertisements to join the nurse bank were ongoing with the ambition to recruit sufficient nurses and care support workers to prevent the need for using agency staff in the future.
- All health care staff were booked to attend or had attended the AIM's training designed to assist staff to recognise the 'deteriorating patient' and take appropriate action.

What is the impact of staffing on caring and responsiveness?

- Patients received compassionate care.
- We saw patient records that were in order and appropriately stored.
- On ward 6 there had been no complaints in the previous six months, yet three had been received in June. The ward manager was also concerned that the patient experience results for June had reduced. The response to the question 'Would patients recommend the ward?' had reduced from 100% to 87%. The results for pain control had reduced to 71% and the results for 'time to discuss patients care and condition' had reduced to 60%.

- Results from the Inpatient Survey (November 2013 to January 2014) indicated the trust was performing better than expected in the waiting list and planned admissions subsection.

Is care in the future likely to be safe?

- Trained nursing staff told us they were tired; working excessive amount of hours to cover uncovered shifts and demoralised from supporting an inexperienced staff group, on a regular basis.
- Trained staff told us they were coping on 'shift to shift' and this had become normalised. Senior trained staff told us they walk in fear of something terrible happening; they worry about the patient safety and ward cover with tired staff, working excessive hours.
- When asked about the future staff felt unable to clearly answer. They were not sure how motivated they could remain or how much more of their own time and effort they could continue to put in.
- The use of bank and agency staff currently exceeded the actual vacancy rate as a large number of staff were currently being requested to provide 1 to 1 nursing for patients who were confused and restless and at high risk of falls.
- We saw and heard evidence that junior staff nurses within surgery were not being appropriately developed which meant that they were not in a position to charge the ward should they be needed. One ward manager told us how they had been innovative and developed their own junior staff when the opportunity arose.

Are surgery services well-led?

We found that the surgical wards were well led by the dedicated ward managers and matron. Staff at ward manager/ matron and divisional manager level told us they were holding the wards together on a day by day basis. The lack of permanent staff had impacted on staff morale and resulted in staff working long hours including their days off.

The theatre staff we met on both sites were part of well led teams demonstrating high standards of care and safety.

Nursing staff told us of the negative effect that occurred since removing discharge co-ordinators from the wards to a capacity office. A team of thirteen staff monitored the wards and departments to assess the bed capacity and the planned discharges. The ward staff felt that they were now an 'ineffective team'. The staff described previous positive

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outcomes regarding the effective social worker and family input and more recently the less positive situations relating to confusion and delayed discharge for some patients. They felt that their importance of patient flow had been overlooked. The impact of medical and surgical patients in surgical beds did highlight a delay in some patient discharges and delays in some areas of investigative procedures.

On day one of the inspection there were 32 medical outliers in surgical beds. On day two there were 26. We were told by nursing staff that the impact of medical outliers on the surgical division had not been recognised by the senior executives. Nursing staff felt that the situation had been poorly managed and no positive action taken to resolve this.

The DATAU was, when necessary remaining open at night, as well as trying to accommodate day case activity. This action put the trust at risk of breaching single sex regulations and increased the risk of adverse incidents occurring. When this occurred, the ward was staffed by nurses from other wards and agency staff. The pressure that ward staff were under to manage both inpatient and day case activity on one unit, as well as managing multiple ward reviews impeded on patient safety. Patient's pathways were being compromised; day case patients at times were being held in recovery, awaiting a bed on DATAU. This was due to beds being occupied by inpatients. A new policy and checklists had been developed to reduce the risk of this occurring. Only 'suitable patients' were to be identified and moved to the day ward.

Cannock hospital was found to be clean and orderly. Patients reported they were happy with their care and felt safe and well looked after. Staff morale was positive; they told us local leadership was good. Staff expressed no concerns about patient safety. Agency staff were rarely required as bank staff were able to cover sickness absences.

Governance, risk management and quality measurement

- In May 2014 it had been noted that improvements were made in relation to mortality reviews within the Surgical Division.
- In June 2014 the Quality, Safety, Effectiveness and Patient Experience Report reported on the impact of current staffing levels was having on patient care. The information suggested that there was no measurable

impact on the quality of nursing interventions, but there has been a dip in patient experience which was seen by a reduced satisfaction in the level of communication and a corresponding increase in complaints received.

- We were shown the May 2014 General Surgery Risk and Patient Safety Report which reported on the incidents within the directorate and reviewed the risk register groups, controls and action taken.
- The trust participated in national audits. Seven orthopaedic surgeons were registered with the National Joint Registry (NJR) to benchmark their performance.
- April 2014 admission pathways were recognised as failing in general surgery, trauma and orthopaedics, ENT and Oral Surgery. The risk score on the risk register has been increased to 20.
- We heard that annual major incident training had not been carried out.

Leadership of service

- There was no clinical director for surgery.
- We were told that more recently senior executives were seen on the wards.
- Ward managers (band 7) had undertaken the trust's ward leadership programme.
- Mandatory training was above 90% in all areas.
- We were told that there was little or no vision or strategy at the trust; it was unclear who was running the trust.
- Staff told us there was a lack of openness and clarity at trust level. They felt that there was a feeling of 'get on with it' to ensure quality care and patient pathways were maintained.
- The theatres at Stafford and Cannock were found to be well run and efficient with good leadership.
- The theatre departments were well supported by all the clinicians.

Culture within the service

- The staff we spoke to told us how they felt they had to carry on maintaining patient safety, but that morale was ever decreasing. Currently, staff told us that there was little or no capacity to learn and innovate.
- All theatre staff displayed a culture of learning and reporting of low harm/no harm incidents.

Staff engagement

- We were told that communication from trust leaders was not always easily understood and inviting nurses to meetings at 5pm was seen to be insensitive.

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- The Deputy Director of Nursing relationship with staff was heard as being positive and supportive.
- The division overall recoded 90.3% for appraisals and 92.1% for mandatory training.
- Monthly governance meetings are held. Mortality and morbidity meetings and quality dashboard reviews were attended by the ward managers.
- Link nurse meetings were held to support staff with professional updates on tissue viability, continence and infection control.
- Team brief was available for all staff to read.

Critical care

Information about the service

The intensive therapy unit (ITU) and high dependency unit (HDU) in Stafford Hospital were located together. There were 10 beds in total. A critical care outreach team assisted with the care of critically ill patients who were on other wards throughout the hospital. The critical care service had consultant cover 24 hours a day. We visited the ITU and HDU and we talked with two patients, one relative and six staff. These included nursing staff at different levels, a consultant, an administrator and managers. We observed care and treatment and looked at one set of care records. Before the inspection, we reviewed performance information from, and about, the hospital.

The trust reported that critical care services had experienced some difficulties sustaining use of seven beds in the unit over the winter period without using agency staff.

Summary of findings

Patients and relatives we spoke with gave us examples of the outstanding care they had received in the unit. Staff worked as a team and built up trusting and consistent relationships with patients and their relatives by working in an open, honest and supportive way. They worked hard at good communication by providing clear information and listening to people.

There was strong local leadership of the units. Openness and honesty was encouraged at all levels. The units were well covered by consultants and registrars and had good, flexible nursing, including senior nurses and stable bank cover.

Quality outcomes were measured, staff were encouraged and supported to report incidents and learning from incidents was passed on through regular staff meetings.

Critical care

Are critical care services safe?

Overall critical care services were safe. All staff we spoke with said they were encouraged to report incidents and received direct feedback by email; themes from incidents were discussed at staff meetings. Staffing levels were appropriate and were sufficiently flexible to provide the level of care that people needed and nurses received the specialist training that they needed to work in this unit.

There was good retention of nursing staff and no problem with recruiting nurses to vacancies. Senior staff were available to support and advise junior staff and there was good team work. The unit had a specialist consultant who was supported by registrars and junior doctors. Nursing staff reported that consultants and registrars were consistently present on the ward, including for two ward rounds each day, and easily accessible to them through on call arrangements out of hours.

Has care been safe in the immediate past?

- All staff we spoke with said they were encouraged to report incidents and received direct feedback by email. Some senior staff said that the reporting system was 'cumbersome' and time consuming and low impact incidents may be under reported. They said this was balanced by good communications within the unit and checks in place from handover of shifts communication. Themes from incidents were discussed at staff meetings.
- Critical Care's quality indicators and outcomes for the period of 1 April 2013 to 30 September 2013 as externally validated by ICNARC London showed:

- Admission criteria into the critical care unit remain of a high standard of clinical appropriateness.

- Positively there were no "non-clinical" transfers out of the trust i.e. only critically ill patients were transferred for clinical reasons only such as requiring specialist neurological input.

Is care safe now?

Nurse staffing levels and skill mix

- The unit had staffing levels that met the needs of patients. All level 3 patients were nursed one-to-one, and all level 2 patients one to two. The unit ran with six nurses for the majority of the time, regardless of whether all beds were full.

- If staffing levels were required to meet an increase in patient's need or a rise in bed occupancy to 7 or 8 patients, the unit used a regular cohort of bank staff drawn from the team who already worked on the unit. Preferential pay rates were offered. A minimal number of agency staff were used. The consultant reported 'good, stable bank and flexible' nursing cover. The unit had sufficient numbers of appropriately qualified staff to be in charge of the ward although some junior staff were quite junior. Band 6 junior sisters had received a lot of training. The trust ran an in house intensive care course for Band 5 nurses and the unit was committed to releasing nurses to attend this training
- Nurses reported that senior staff were always available to them for advice and support.
- There were 3 senior sisters and a nurse consultant attached to the unit.
- The critical care outreach team was available 24 hours, 7 days a week, was staffed by 8 full time equivalent nurses and managed by Band 7 nurses who reported to the Nurse Consultant.
- The unit did not have problems recruiting or retaining senior staff and their service at the hospital ranged between ten and thirty years.

Medical staffing levels and skill mix

- Care in the ITU/HDU was led by a consultant in intensive care. A consultant was present on the unit from 8.30 am to 5pm on weekdays. Outside these hours, a consultant was able to attend the unit within 15 or 20 minutes if required. Consultants attended on weekend and public holidays for the morning ward round and stayed on in the ward if necessary or returned home where they were on call. Nursing staff found consultant cover accessible and responsive.
- The consultant to patient ratio was 1:10 and this did not exceed the national recommendations of 1:14.
- The consultants worked in ITU/HDU in consecutive four day followed by three day blocks. They undertook ward rounds twice daily. All potential admissions had to be reviewed by a registrar and discussed with a consultant and all new admissions were reviewed in person by a consultant within 12 hours of admission.
- Consultants were supported by a team of other doctors that included a specialist registrar, an anaesthetist and junior doctors.
- Pharmacists came into the unit each day to support the medication administration round.

Critical care

- The consultant reported that there were ‘plenty of registrars’ as the unit was very popular for learning about intensive care medicine.

What is the impact of staffing on caring and responsiveness?

- Patients and relatives reported: good care with ‘plenty’ of staff to meet their needs; staff were responsive to people’s needs at night including their emotional needs; students also appeared competent. There was good team work and staff kept patients and relatives informed of what they were doing and what had been done.
- There were some delays in discharge created by flow issues through the hospital. ICNARC data demonstrated that delays to discharge were significantly higher than national comparators. During our inspection one patient was waiting for a bed to become available in ward 8 before discharge from the high dependency unit.

Is care in the future likely to be safe?

- Student nurses actively seek to be recruited by the critical care unit. A recent Band 5 nurse recruitment was ‘inundated’ with good quality applicants.
- The outreach service was recruiting to two vacant Band 7 posts and had attracted good calibre applicants.
- The turnover of health care assistants was relatively high on ITU/HDU. Their role was mainly cleaning and ordering and did not include care tasks, as would be the case on other types of wards. Two health care assistants did have long service with the unit.
- Critical care was commissioned for up to 5 beds in intensive care (ITU) and 4 in high dependency (HDU) and which could be flexibly managed to provide up to 10 beds.
- There was good retention of nursing staff. The unit had recovered from the recent vacancy gap and reported recruiting good quality staff, including from a neighbouring NHS Trust.

Are critical care services well-led?

There was strong local leadership of the intensive care and high dependency unit and the outreach team. Senior staff were available to support and guide junior staff and there was an ethos of team work. Good communication and

continuity of care was prioritised by managers. Patients and relatives were kept informed and listened to. Openness and honesty was the expectation for the unit and encouraged at all levels.

Staff received information from ward managers about changes and any future plans affecting the unit. Risks were being managed appropriately and staff were involved in quality improvement projects. Trust wide information on safety issues was promoted through the intranet and weekly bulletins but there was no visible evidence of the trust’s vision and values statements within the unit.

Governance, risk management and quality measurement

- Critical Care’s quality indicators and outcomes were externally validated by ICNARC London.
- The NHS Safety Thermometer was completed monthly by a senior nurse with specific responsibility for this.
- Quality target data was collected for infection control, falls and Waterlow scores. There was an infection control visual alert system present around each bed space. Ward sisters received personal feedback by e mail on the unit’s performance against quality indicators.
- Learning from incident investigations was fed back to staff at monthly meetings and direct e mail feedback to the staff who reported the incident is mandatory within the trust.

Leadership of service

- The intensive/critical care unit was led by three senior nurses, a consultant nurse and consultant clinician.
- There was strong local leadership of the unit. Each senior sister carried a specific management brief including for quality, training and human resources.
- The outreach team was managed by a senior sister who reported to the nurse consultant.
- Each shift was led by sisters who had supervisory responsibility for the staff working for them. Some sisters were ‘quite’ junior but had undertaken the in house intensive care course.
- Nurses told us that there was always senior staff available to ask for advice or support.
- There was an ethos of team work within the unit and this was confirmed by patients we spoke with.

Culture within the service

- Staff within the unit spoke positively about the service they provided for patients.

Critical care

- Good communication and continuity of care by nurses in charge of individual patients was prioritised by managers.
- Relatives and patients told us they were kept well informed and also listened to by staff.
- Quality and patient experience were seen as priorities and everyone's responsibility. Openness and honesty was the expectation for the unit and encouraged at all levels. We observed shift and unit leaders who were compassionate and led by example. Patients we spoke with confirmed this was the case, including overnight.
- Staff were encouraged to complete incident forms or raise concerns and sending feedback to staff in writing was compulsory.
- Staff worked well together and there was obvious respect. Staff were engaged and worked well with other departments within the hospital and with local community care professionals.
- Staff reported seeing trust wide information and feedback on safety issues on the intranet and in a weekly communications bulletin.
- Staff reported they had an annual performance review last year.
- Nursing staff told us they got 'a good information flow' from the consultant nurse about changes and any future plans affecting the unit.
- We noted that there was information on public display in the unit about achievement against quality targets including for infection control and falls. However this was presented in too complex a format to be understood. Unit managers told us this was being improved and would be replaced by a simpler matrix format in August 2014.
- Nursing staff positively described a new computerised system for intravenous fluids administration that had been developed by a consultant at the unit.
- Senior nursing staff received feedback on quality outcomes for the unit by personal e mail. They told us the unit's performance was 'excellent' and they were 'overwhelmed' by people's generosity with financial donations and other small tokens of gratitude.

Public and staff engagement

- We saw no evidence on display in the unit of the trust's values or vision statements.

Maternity and gynaecology

Information about the service

The maternity service at MSFT opened in 1984 with a capacity to deliver 2500 women. The number of deliveries has declined over recent years and is currently around 1,800 babies annually. The maternity unit is located within the Obstetric and Gynaecology Directorate and includes a delivery suite and a midwifery led unit (MLU). Women attend their hospital outpatient as well as some antenatal appointments at the hospital. The hospital has also recently introduced a system for seeing women and their babies postnatally.

The antenatal / postnatal ward consists of 20 beds, there is also a day assessment unit situated within the ward (Ward 9). The labour ward is on the same floor and within close proximity to Ward 9.

Ward 9 consists of single, two or three bedded areas as well as an obstetric day care provision. There are two theatres one for obstetrics and the other for elective gynaecology, the latter can be used as a second emergency theatre for obstetrics if required.

Community midwives are employed by the hospital who care for women and their babies both antenally and postnatally; all community midwives are aligned to a GP practice.

We visited all inpatient areas of the maternity service and talked to midwives, support workers, the head of midwifery, medical staff as well as women and their partners on Ward 9.

Summary of findings

Good care is provided for women and babies. We were told that women were satisfied with the care they had received and this was supported by evidence in local and national surveys. The staff reported that the department was a friendly and supportive environment to work in but that it could become busy at times.

There were processes in place for reporting, responding to and learning from incidents although more could be done to encourage staff to take part in generalised learning opportunities.

Staff reported uncertainties about the future which impacted on morale but that they were following a business as usual model.

Maternity and gynaecology

Are maternity and gynaecology services safe?

The maternity department at Mid Staffordshire Hospital was well staffed with few vacancies, although some members of staff we spoke with reported that Ward 9 could become busy at times. We reviewed a sample of handover notes and incidents and there were no reported incidents around staffing. It was reported that the escalation policy had not been required since March 2014.

Staff reported that the department was a friendly and supportive environment to work in and it was very apparent that staff across all levels worked well together. We were told that the culture was very open and that staff were encouraged to report concerns.

There were systems in place for reporting and responding to incidents which worked well. The monthly dashboard indicated that women and their babies were well cared for and there were no specific clinical outliers, however, reported activity was higher than expected for the number of women undergoing an induction of labour and / or an emergency caesarean. We were told that this was due to the department following national guidance on the 'normalisation' of births and that as a direct result the inductions and emergency caesareans had increased.

We were told by staff that women received an epidural if they requested one and that they did not have to wait very long. This was supported by a recent audit undertaken in 2014 which reported that the maternity department had exceeded the standards set by the Royal College of Anaesthetists (RCOA).

Has care been safe in the immediate past?

- The Local Supervisory Authority undertook an annual audit in February 2014. The audit focussed on supervision and leadership arrangements. The report highlighted some areas of strong performance and recognised the difficulties faced by midwives during the trusts period of administration. Some recommendations were listed and the trust was expected to produce an action plan by the end of July 2014.
- Many national / internal targets were reached or exceeded; all clinical indicators were reported as

achieved, with exception of the number of complaints for March only and the number of babies being readmitted with feeding problems was also high in March.

- Performance against activity related targets reported more mixed results. The maternity department performed well for the percentage of women booked for their first appointment within the relevant timeframe and the percentage of elective caesarean sections.
- The induction rate was much higher than expected, the number of spontaneous vaginal deliveries and normal deliveries were also higher than expected as were the number of emergency caesareans. We were told that this was due to the department following national guidance on the 'normalisation' of births and that as a direct result the inductions and emergency caesareans had increased.
- We noted that the scheduled caesarean rate was lower than or equal to the target level and that overall combined emergency and elective caesarean target had been achieved each month in 2014.
- We were provided with a narrative summary of an audit on time taken for women to deliver a baby once a decision had been made to perform an emergency caesarean section. In accordance with national requirements the decision to delivery should be within 30 minutes for category 1 emergency caesarean sections and within 75 minutes for category 2. The trust reported that of 100 emergency caesarean sections 95% of all category 1 and 98% of all category 2 caesareans had been performed within the required timescales.
- There was a system in place for reporting incidents and staff told us that they felt confident in reporting and that they were supported to do so. We saw that there had only been two serious incidents reported in 2014. Staff told us that they received feedback from their Line Manager once the investigation had been completed informing them of outcomes and any actions required.
- There were systems in place for shared learning, monthly meetings were held for example the mortality meeting which was open for all staff to attend, however, the staff we spoke with reported that they were either not aware of the meetings or that they did not have time to attend. We reviewed a sample of incidents and noted that action taken had been documented.
- We reviewed the investigation reports and action plans for the two serious incidents. Investigations were clearly documented and identified shortcomings as well as

Maternity and gynaecology

notable areas of practice. Recommendations were clearly defined with a lead assigned to each recommendation and we saw examples of its implementation.

Is care safe now?

- Staff felt that good care was provided to the women and their babies but that it could become busy at times, particularly on Ward 9. The women we spoke with were all very satisfied with the care they had received.
- Midwifery staff reported that staffing levels were good on the labour ward, the number of midwives on labour ward had recently increased from four to five, the staff we spoke with reported that this had improved the care provided to women.
- Staffing levels on Ward 9 consisted of two midwives and one healthcare assistant and that when the ward was quiet this worked very well. However, if there were a high number of women who had undergone a caesarean or a high number of babies receiving transitional care this made the ward busy.
- Where possible, a midwife would be transferred from labour ward or the community or that labour ward would care for a woman for longer before transferring them to Ward 9. Women could also be discharged directly from labour ward. We were told that this was managed well most of the time but at times staff were 'stretched' on Ward 9. When the Ward was very busy, this meant that midwives and healthcare assistant could not spend as much time caring for women.
- The department had an escalation policy in place which stipulated the optimal number of midwives and healthcare assistants. The policy stated that a calculus for when to implement the policy had not been determined as this would depend on acuity of women and babies within the department. It was noted that the policy had not been reviewed since November 2012 and that in this time adjustments had been made to the staffing levels. It was reported to us that the escalation policy had not needed to be implemented since March 2014. There was no clear guidance detailing trigger points when staff increases should occur.
- The staff and women we spoke with told us that required pain relief was available during labour as required. We were told that women were able to receive an epidural if they wanted to if it was clinically appropriate. This was supported by the summary findings of an audit undertaken in 2014 on the time taken for women to receive an epidural. The results provided to us demonstrated that the trust had exceeded the Royal College of Anaesthetists (RCoA) requirements of ensuring that 80% of women should be seen by an anaesthetist within 30 minutes and 90% within 60 minutes.
- Staff told us that they did not always report staffing shortages as an incident because if they were extremely busy then they did not always have time but it was recorded on the handover sheets. We reviewed a sample of handover sheets and found that where shortages had been recorded, cover had been arranged or activity was low.
- There was adequate consultant cover in accordance with national guidelines and on-call arrangements were in place. We were told that there were a shortage of middle grade doctors and that consultants were providing cover for any shortfall in middle grade doctors.
- Some staff also told us that equipment was not always readily available, in particular blood pressure machines and thermometers and although these could always be found eventually, much time was wasted searching for them.
- The staff we spoke with told us that induction and mandatory training was a high priority and that the standard of training was sufficient to ensure staff were kept up to date with relevant skills. We were told that all new employees had a period where they were supernumerary which meant that they were able to shadow other staff. One member of staff told us that they had not felt fully confident at the end of their supernumerary period and that they were told this could be extended further if they required additional support. Attendance at training for midwives, healthcare assistants and clerical staff was high; between 78 and 94%.
- We were told that the skill mix worked well and that there was always a band 7 midwife in charge of the shift, supported by a mixture of band 5 and 6 midwives on labour ward and a minimum of one band 5 and one band 6 midwife on ward 9.
- The ratio for supervisors to midwives was in line with national standards and it was reported to us that 90% of midwives had attended their annual supervision.

Maternity and gynaecology

What is the impact of staffing on caring and responsiveness?

- Results from the CQC Maternity Survey indicated that the trust is performing similarly to other trusts for the care they received during labour and birth and above average for care received in hospital after birth.
- The 2013 Maternity survey indicated that the trust were equal to other maternity departments for care provided during labour and birth and better than expected for care provided in hospital following birth.
- The most recent friends and family test results for June reported that patients were either likely or highly likely to recommend the service to a friend, the department had a higher than average response rate and no negative feedback was received through this medium. We were told that as a result of previous feedback, comfortable chairs had been purchased for dads to stay overnight.
- It was the perception of midwives that the department could become exceptionally busy at times, for example if there were a high number of women who had had a caesarean section or if there were a high number of babies receiving transitional care. There were no clearly defined guidelines to determine when a critical level had been reached. We were told that when the department became busy this meant that the midwives could not spend as much time with the women to support and care for them.

Is care in the future likely to be safe?

- Current recruitment arrangements worked well and the vacancy rate was low compared to the England average. Cover for absence was arranged through the bank or the community on-call rota and agency is not used or needed to cover midwifery or healthcare assistant absences.
- There were no vacancies for obstetricians and suitable cover was arranged in accordance with the rota.
- Based on current medical and midwifery staffing arrangements, cover provided was reasonable although improvements could be made to arrangements for ward 9.
- Current arrangements for the maternity department worked well, however, there have been minimal discussions and currently no plans developed for the

transition period or post transition period. There is a lack of information for staff and management within the department to make informed decisions about how to manage the transition period and beyond.

Are maternity and gynaecology services well-led?

The maternity department has a clearly defined governance structure in place. Meetings are held at which the complaints, incidents, risk register are discussed. We saw that the dashboard was also presented but that there was limited evidence of discussion around performance which was lower than expected.

There was a positive culture within the department and most staff reported that the team worked well together and they felt confident in reporting concerns if they needed to.

We saw that attendance at meetings was predominantly for senior management from within the department or specialist clinical roles. More could be done to encourage other staff to attend meetings to enhance learning.

There was evidence of some communication having taken place between the trust and others regarding planning for changes to how the maternity department is operated in the future. However, there was no formalised plan to take things forward.

Governance, risk management and quality measurement

- There were clearly defined governance reporting systems for Obstetrics and Gynaecology, a number of sub groups had been formed which reported into the Obstetrics and Gynaecology Governance Group which met monthly and in turn reported to the Clinical Quality Review Meeting.
- We reviewed the June 2014 minutes. The maternity dashboard was presented at the meeting, however, there was no evidence of discussion. Minutes simply recorded performance against some of the targets but there was no evidence that where a target had not been met or not met consistently that this had been considered or discussed; there was limited evidence of discussion around proposed action.

Maternity and gynaecology

- We noted that the risk register, as well as complaints and incidents which had occurred in the previous month were reported and that historic serious incidents which had been investigated and closed were also reported via the Clinical Risk Group.
- We reviewed the risk register for maternity which had four identified risks, each risk was clearly defined with details of controls in place and actions required, target dates for implementation of any actions were current although the review record for risks had not been updated. It was also noted that some significant risks faced by the department had not been included on the register, for example, the uncertainty around the future of the department during and post the administration process had not been documented and serious incidents had not been flagged as risks.
- The midwives and healthcare assistants we spoke with told us they felt comfortable in speaking to their Line Manager about any concerns but that they could also approach the Head of Midwifery who had an 'open door' policy.
- Staff told us that they all worked well together and as a team and that there was respect between staff at all levels within the department. However, staff were concerned about the lack of information available about changes expected to be made to the service and that this had an affect on staff morale.

Public and staff engagement

- Current arrangements for the maternity department worked well, we saw that meetings were being held between the trust, the TSA as well as other local trusts affected by any changes in the maternity service. Meetings focussed on the planning principles/timeline, the target operating model, the Clinical pathways, requirements and milestones. A formal plan for the transition period had not been developed.
- We spoke to staff about meetings they could attend within the department. Some staff were aware of open meetings but not all and although some staff were aware, they reported that they did not usually have time to attend.

Leadership of service

- The maternity service had a Head of Midwifery and a Consultant lead for the service. There were clear reporting lines for midwives and medical staff.

Culture within the service

- The majority of staff we spoke with spoke positively about the maternity department. Staff told us that they felt well supported and that when they raised concerns they were listened to. Staff told us that they were confident in reporting incidents and felt they would continue to be supported to make improvements if required following an incident.

Outpatients and diagnostic imaging

Information about the service

The Trust operates radiology services from two hospital sites, Mid Stafford Hospital and Cannock Chase Hospital, and the department employs around 60 members of staff across both sites, serving a combined population of 276,000. The Inspection team visited the radiology department at Mid Staffordshire site only.

Mid Staffordshire Radiology department provides care for both paediatric and adult patients. Referrals are received from hospital wards, A & E (accident and emergency), GPs and external neighbouring acute services. Between April 2013 and March 2014 the radiology service carried out approximately 56,448 examinations. This is set to reduce significantly in August and September 2014 when some elective examinations at Mid Stafford radiology department are discontinued.

The service is located on the ground floor of the hospital and has easy access for inpatient and outpatients visitors. The service operates a 24-hour a day service and provides a range of procedures to include: plain X-ray, ultrasound, CT (computerised tomography) and interventional procedures. Only plain X-ray and CT are available out of hours. Patients who require an MRI (magnetic resonance imaging) are referred to Cannock Chase Hospital.

We visited the Radiology service and talked to six patients and 42 staff of different grades, this included consultant radiologists, radiographers, managers and deputy managers, sonographers, nurses, radiology department assistant and admin staff. We talked to 15 additional doctors from A & E and five different wards to gather feedback about the in house radiology service provision.

Summary of findings

The radiology service of Mid Staffordshire hospital was providing a safe service at the time of our inspection. Radiologist staffing levels have reduced significantly during the past few months and are set to reduce further during August and September 2014. However, the service has put in place a strategy to address current and future radiology staffing levels making the service sustainable until November 2014.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Staff were aware of safe systems, processes and practices including, for example, safeguarding alerts and incident reporting procedures, also demonstrating good infection control practices. The department was in a good structural state of repair. There was adequate supply of equipment which was serviced at regular intervals. Care was delivered by evidence based practice and followed recognised and approved national guidance. Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies. At the time of the visit, radiologist staffing levels had already been reduced by half and the department had put in place radical plans to address concerns and minimise the risk to patients. Some of the plans had been already been implemented and some were being introduced over the next few weeks in anticipation of further loss of radiology staff. Despite current and future staffing concerns the department was meeting its national reporting targets and was providing a safe service to hospital wards and the A & E department.

Has care been safe in the immediate past?

- Between January 2014 and June 2014 there had been 12 incidents reported from the radiology department. All of these were classed as minor to moderate severity incidents.
- There was a consistent approach to escalating and investigating incidents with robust action plans to address concerns.
- Learning and changes to practice were communicated through monthly governance meetings and communicated to staff when the department had capacity to do so.
- Staff told us weekly team meetings were not as regular since the department had experienced staffing shortages.

Is care safe now?

Radiographer and Sonographer staffing levels.

- The department is fully staffed for radiographers and sonographers and has 35 and 5 respectively.

Nursing staffing levels.

- There were four nurses working within the department, one fulltime nurse and three part time nurses. Two part time nurses were on sick leave.
- Bank or agency nurse back fill was supplied when there was capacity. There was no nursing backfill during the inspection period.
- Nurses told us they often work late to ensure nursing duties are completed, nursing shortages did not impact on safe service delivery.

Radiology staffing levels.

- The department has seen a steady reduction in Radiologists over the past 12 months. The service is funded for 10.6 full time radiologists. There are now five full time radiologists and two locum radiologists.
- From August 2014 this will reduce further to two radiologists and two locum radiologists and part time support from radiologists based at UHNS.
- Unsuccessful attempts to recruit radiologists into posts were due to; general national shortage of radiologists, limited specialist development opportunities, Mid Staffordshire's poor reputation and uncertainty of job security.
- Funding for five radiology posts had been transferred to UHNS (University Hospital North Staffordshire Trust) who have agreed to take over the recruitment process. To date they have been unsuccessful.
- There are no further plans to provide radiologists from neighbouring trusts.

What is the impact of staffing on caring and responsiveness?

- Care provided by staff was respectful and dignified.
- Examinations were unhurried and staff maintained patient confidentiality in public areas.
- Patients told us they felt staff were caring and kind and kept them informed.
- Provision of care and timely diagnostics was not affected by the shortage of radiologist.
- National report turn around timescales was met. For example, cancer and urgent examinations were completed within two weeks and routine examinations were completed within six weeks or less.

Outpatients and diagnostic imaging

- We talked to 15 doctors from A & E department and hospital wards who confirmed internal requests for radiology examinations were carried out within 24 hours or less and examination results were within acceptable timescales.
- The shortage of radiologists did not delay diagnosis and delays in patient's length of stay were not attributable to the radiology department.
- Radiologist staff shortages could sometimes result in no representation at multidisciplinary team. There was always a duty radiologist available to offer advice to sonographers but with reduced numbers of radiologists specific expertise was not always accessible. When this happened the ultrasound report would reflect this.

Is care in the future likely to be safe?

- Radiologist staffing levels were inadequate with only five substantive radiologists and two locums and concerns are heightened for August and September 2014, when levels will plummet to two full time radiologists and two locums.
- However, radical strategy plans have been implemented to address these concerns:
 - The department will outsource to a second private contractor for interpretation of investigations to reduce workload for Mid Staffordshire radiologists.
 - Installation of a medical remote imaging reporting system by mid-August 2014. This is an image portal enabling the sharing of data between MSFT and UHNS for the purpose of increasing reporting capacity.
 - Eleven services will see a staged discontinuance - these services will be redirected to UHNS or RWT (The Royal Wolverhampton NHS Trust). From 1 August 2014 two services will be discontinued from the Mid Staffordshire site and from 1 September 2014 a further nine services will be discontinued.
 - Three further services will see restricted availability, however support has been requested by neighbouring trusts, for example RWT and UHNS.
 - All services to be discontinued are elective and classed as non-urgent.

- All urgent services will continue to be accepted at Mid Staffordshire radiology. However, there may be instances where patients will have their examinations at MSFT and will be redirected to UHNS via ambulance for reporting and further care and treatment.
- By discontinuing services patients will be adversely affected with lengthened travelling time to UHNS and RWT and the inability to access elective radiology services close to home.

What alternatives to staffing on site have been considered and/or implemented?

- MSFT Radiologists feel that the strategy plan will work with three provisos:
 1. The two identified private contractors have the capacity to meet all outsourced work from MSFT.
 2. Between now and November 2014 the remaining two substantive radiologists and two locum radiologists will remain in post.
 3. Successful installation and implementation of the medical remote imaging reporting system by mid-August 2014.

Are outpatient and diagnostic imaging services well-led?

The radiology department was well led. Despite radiologist shortages the department continued to lead with vigour and encouraged staff to provide safe and effective care to patients. Staff had faith in the radiology management team and felt well supported. However, staff were worried they were losing the radiology service manager and clinical lead and felt uncertain about the future of the department and their individual job security.

Governance, risk management and quality measurement

- There was a standard operating procedure for each examination carried out jointly reviewed annually by senior and junior staff.
- Documents within the department relating to IRMER (Ionising medical exposure radiation regulations) procedures and standard operating procedures (SOP) were embedded in a Quality Management System (QMS). A QMS is a recognised and accredited document repository (electronic) which allows all documents to be

Outpatients and diagnostic imaging

electronically stored and the document author prompted to audit and review documents at set periods. This means only the most up to date version of the document is available to staff.

- Clinical and public areas were risk assessed and actions taken to address concerns. For example, lead sliding doors to an office, previously used as an examination room was considered as a health and safety risk to staff due to the weight of the door. Plans were in place to replace the door with a more suitable design.
- Radiology equipment had undergone a risk assessment under the Ionising Radiation Regulations (1999)
- Attendance at the Radiation Protection Committee was good and the group met annually or bi annually if at Quorate. The committee discuss the safe use of radioactive material, x-ray equipment and other sources of ionising radiation. Minutes were disseminated to staff within the department.

Leadership of service

- The radiology service was managed jointly by the general manager and radiology service manager
- Staff told us they felt well supported by the clinical lead and the radiology service manager. Radiographers and sonographers told us they received regular appraisals and supervision. However, both the clinical lead and the radiology service manager were transferring to UHNS within one month and one day respectively.
- There were plans in place to recruit to the radiology service manager post, but no plans to replace the clinical lead. This meant staff felt vulnerable and the radiology department would be left without clinical leadership from August 2014 onwards.
- Nurses were not supported with professional development. They had no clinical supervision in place and no direct nursing manager to report to. They were told to report to the outpatient matron who was on long term sick leave. Nursing staff felt clinically let down and disillusioned with current and future nursing support.

Culture within the service

- Staff within the radiology department spoke positively about the service they provided for patients.
- Despite staff shortages they worked well as a team and demonstrated an open and eagerness to learn and develop. For example, staff had adopted different techniques in CT scanning which improved how they delivered imaging.
- Staff were committed to support in each other and demonstrated a culture of 'knuckling down' to provide the best care possible.
- There was a good standard of radiation protection awareness and a culture of safe working practices under both sets of Radiation Regulations.
- Staff retention appeared good, as evidenced by no vacancies in posts apart from radiologists

Public and staff engagement

- The radiology department had stopped collecting patient feedback several weeks ago.
- Staff told us they did not have time to collect patient feedback and told us it was pointless as the future of the department was undecided. In addition, they mentioned that they were not confident the feedback would be balanced due to patients providing only positive comments to preserve MSFT reputation.
- All six patients we talked to told us the radiology department provided good to excellent care. Staff were caring and efficient and they were kept informed by letter and by the consultant on the day of their examinations.
- Staff told us they felt well informed by the radiology department; however they felt angry and frustrated about the lack of information from the TSA.
- Staff told us they had not received any communication from the TSA about the future of the department and felt that's why some staff had left and radiologist recruitment was unsuccessful.