The Royal Wolverhampton NHS Trust

Cannock Chase Hospital

Quality Report

Brunswick Road, Cannock, Staffordshire, WS11 5XY
Tel: 01543572757 Date of inspection visit: 02 - 05 June 2015
Website: www.royalwolverhamptonhospitals.nhs.uk Date of publication: 13/12/2016

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

Ratings

Overall rating for this hospital	Requires improvement
Minor injuries unit	Good
Medical care	Requires improvement
Surgery	Good
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection 02 to 05 June 2015. It was an announced comprehensive inspection. This trust had been inspected in the first wave of the comprehensive programme November 2013. Our rationale for undertaking this inspection was to rate the trust because the initial inspections did not receive a rating. In addition to this the trust had taken over services from the dissolved Mid Staffordshire NHS Trust, which included Cannock Chase Hospital. The trust had previously stated its intention to become a Foundation trust, but had had to postpone the application a number of times. Allowing them to address current matters such as the integration of new services appropriately.

Within Cannock Chase Hospital there are services which are offered to the public by other providers, we did not inspect those. All services offered by the Royal Wolverhampton Trust at Cannock Chase hospital were inspected.

We found this location to require improvement. The integration process started 01 November 2014 and we have endeavoured to ensure our inspection is confined to post that date. We recognise that the integration of the service is more than a contract and date, it involves staff and users and we saw there were some teething issues which still required input to resolve.

We saw that some of the processes did not support good patient outcomes namely in the Medical rehabilitation ward and Outpatients and diagnostics.

Our key findings were as follows:

- Staffing levels were not sufficient to meet the needs of patient in the Minor Injuries Unit (MIU). We also saw that staff on the medical ward were fatigued and felt this was because they were required to cover shift shortfalls via the bank.
- Surgery services were good on the whole, demonstrating that patient care was safe and effective.
- The integration process was in progress and we saw where continued work was required. For instance in Surgery there needed to be a process for identifying the best practice and incorporating that into the trust as a whole. Within medicine we saw that the staff felt isolated from the New Cross Site. We also noted that in MIU they did not fully understand how they fitted into the vision of the trust with regard to the Emergency service strategy.
- The end of life service was meeting the needs of the people and staff. There was complete 'buy-in' of the staff with regard to the implementation of the Swan Project.
- Governance arrangements in Outpatients and diagnostics needed to be strengthened. We saw that appraisals for qualified staff were not undertaken in outpatients. Within diagnostics there were a number of challenges such as the radiation risk assessments being generic and the use of two types of referral form for the same procedures.
- Care was consistently good throughout the service. We saw that patients we recommend friends and family to use the service. We received good feedback from patients and visitors about the care they had receive in the hospital.

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

Importantly, the trust must:

- The trust must put in place effective systems to monitor outcomes for patients.
- The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
- The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations.

These represents a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) Regulation 17: Good Governance

In addition the trust should:

Summary of findings

Minor Injuries Unit

1. The trust should improve risk management for the MIU including demonstrating how it has assessed and how it safely manages the lack of access to x ray facilities for patients and the lack of privacy at the reception desk.
2. The trust should improve the uptake of mandatory staff training at the MIU and provide staff with dementia awareness training.
3. The trust should support the MIU service to participate in appropriate audit activity.
4. The trust should support the MIU service to monitor outcomes for its patients including those transferred to the ED, and to provide key performance indicators, including waiting times, and other access and flow indicators.
5. The trust should effectively communicate a clear vision for this service.
6. The trust should strengthen Governance arrangements to support continuous improvement and manage risk strategically and more effectively.

Medicine

1. The trust should ensure that broken equipment is fixed in a timely manner.
2. The trust should ensure that all equipment such as nutrition feeding equipment pumps are portable appliance tested (PAT).
3. The trust should ensure that the protocols be documented regarding wound care.

Surgery

1. The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
2. The trust should have in place a major incident plan for all the services. Staff should be aware of this plan as it relates to their specific service.
3. The trust should make sure that there are process in place to ensure formal “sign in” takes place in the anaesthetic room.
4. The hospital should ensure operating lists are published in a timely manner.
5. The trust must make sure that the integration of the service is undertaken by engaging clinicians at all levels in an inclusive manner.

OPD Diagnostics

1. The trust should ensure that all staff receives post-incident feedback, shared learning and changes in practice related to incidents.
2. The trust should ensure that all staff receives safeguarding training in the protection of vulnerable adults and children.
3. The trust should ensure that the procedure to check whether women were pregnant prior to receiving radiography tests is improved to be in line with professional body guidance.
4. The trust should ensure that the disabled cubicle in radiography is improved to ensure the call bell and curtain is fit for purpose.
5. The trust should improve radiation risk assessments to ensure they are fit for purpose.
6. The trust should standardise radiology referral forms and ensure that they adequately record the information required by IR(ME)R.
7. The trust should ensure that all staff in outpatients receives their appraisals.
8. The trust should try to improve waiting times in outpatients and radiology and keep patients informed of delays.
9. The trust should ensure that appointment letters and patient information leaflets are accessible in languages other than English.
10. The trust should ensure that there are facilities to provide food and drink to patients in outpatients and radiology.

Summary of findings

11. The trust should ensure that senior management support and empower staff to make changes and drive improvements within both outpatients and radiography.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Minor injuries unit	Good	We found that the safety of the service to be good overall but with some improvement required. Staff reported, investigated and learned from incidents. There were systems in use to control infection, safely manage medicines, maintain records and safeguard children and vulnerable adults. Staffing levels were not sufficiently robust to provide the service although this was being addressed by the trust. Some risks to patients were not being properly addressed by the trust such as the lack of access to x ray. Nurses were emergency medicine practitioners (ENP) and this meant they could prescribe drugs. The lead nurse was qualified to care for sick children. No staff however had advanced paediatrics life support training. We found services required improvements. There was a lack of audit undertaken. The MIU was using nationally agreed protocols to ensure quality of care although there was no system in place to monitor the outcomes for patients. Staff were qualified and had the skills and support they needed to carry out their roles effectively and in line with best practice. The MIU had good joint working with other trust services They referred patients directly to Ear, Nose and Throat, Paediatric and Maternity services. We found the service was caring. Feedback from people who used the service, those who are close to them and other stakeholders was positive about the way staff treated people. People were treated with dignity, respect and kindness. The MIU could access a range of emotional support services provided by the trust for patients. The size and layout of the reception area however meant that patients had no privacy in their conversation with the receptionist. We found services were responsive. The MIU was open seven days a week from 10.30 am to 6.30pm. People could access the right care at the right time except for x ray imaging. Access to care was managed to take account of people's needs, including those with urgent needs or complex conditions such as living with a learning disability. There was no performance information regularly collected to show whether the MIU was performing

Summary of findings

well or badly on key performance indicators, including waiting times, and other access and flow patient's indicators. Complaints were dealt with in an open and transparent way.
We found leadership of the service to be good but required some improvements. In its Annual Report for 2014/15 the trust said emergency and urgent care (ED) was its first priority for 2015/16. There was little information about how the MIU was to fit into the vision and strategy. ED directorate leaders were visible and available to the MIU and local leaders showed a firm leadership and there was a friendly, open culture of teamwork and concern for patients. The trust and MIU had started to work well on quality issues. However there had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. The trust had not undertaken any comprehensive risk assessment and management plan for the service before or immediately after it had taken it over in March 2015.
We visited the MIU on 4 and 5 June 2015 and spent a total of four hours there. We spoke with two nurses, the lead nurse and the administrator and followed the care and treatment of one patient.

Medical care — **Requires improvement**

The overall rating of this service is that it requires improvement.
The ward's track record on safety showed that improvements were required to protect patients from harm. There were many patients falling and some had sustained harm. Some poor infection control practices were seen during the inspection. Lessons were learnt when things had gone wrong but improvements were still on-going. Staff had not received duty of candour training and there was no evidence to suggest that this was being met.
There were systems, processes and practices in place to keep patients safe but they were not always reliable. Out of date medicines including insulin was being stored in the medication refrigerator on the ward. Checks on feeding equipment were found not to be up to date with required portable appliance testing (PAT).
Risks to patients using the services were assessed and their safety monitored but the maintenance of these were fragile. The ward was covering their own

Summary of findings

nursing staffing shortfalls on a continual basis with limited access to bank or agency cover which was unsustainable. Staff felt that reporting when they were short staffed was discouraged.
Risks to the service were anticipated and planned for but these were at ward level and were not always linked with the rest of the trust. Beds were broken on the ward and had not been repaired or available for patients in a timely manner.
Patients' needs were assessed and basic nursing provided but care and treatment were not always delivered in line with standards and evidence based guidance. The documentation of wound care was not consistent and did not clearly state how the wound was to be managed.
Key outcomes show that the length of patients stay and the readmission rates were higher than expected. However, key performance data to monitor effectiveness regarding management of complex discharge planning was collected.
Patient consent to treatment was sought but the awareness regarding legislation required strengthening and improving.
Staff did have skills, knowledge and experience to deliver effective care and treatment.
Multidisciplinary (MDT) working was evident.
Overall we found that patients were treated with kindness, dignity, respect and compassion on Fairoak Ward. Patients and those close to them were involved in decisions about their care particularly in relation to discharge planning.
Patients concerns and complaints were listened to and resolved locally and there was a very low number of formal complaints. However there was no evidence of using this information to improve the quality of care.
Patients could access care and treatment in a timely way; however staff were concerned about patients being transferred to the ward overnight.
There was not a clear shared vision at ward level. The nursing staff appeared to be isolated managerially, operationally and professionally and were not able to provide improvements to the service. The local leadership required time, capacity and support in order to promote good quality care and ensure that services could be continuously improved.

Summary of findings

The governance framework was present at directorate level but not fully engaged with at ward level. This meant that any concerns regarding Fairoak Ward may not always be raised formally and key safety and governance messages may not always be shared directly.

Surgery

Good

Patient safety was monitored on a daily basis. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.

Services were planned and delivered to meet the needs of local people. However, we found that operating lists were published only the day before the operation.

There were systems in place to support vulnerable patients. Concerns were addressed at a local level before the issues resulted in a complaint.

There was clearly visible leadership within the surgical services. However, staff did highlight concerns that there was a tendency for the hospital to adopt new ways of working regardless of perceived value of the new system.

End of life care

Good

The Specialist Palliative Care Team (SPCT) provided a safe, effective and responsive service for people with life-limiting illnesses. The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced. The palliative team were in the process of embedding the Swan Project at both hospital sites

Summary of findings

as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) and staff returned jewellery in a small box. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information leaflet' and the feedback survey was redesigned to have the Swan logo.

The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few end of life patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.

The Specialist Palliative Care Team worked closely with Cannock Chase Hospital to support patient pathways through the hospital.

The staff knew how to make referrals and people were appropriately referred to and assessed by the SPCT in a timely fashion. Seven day working was not in place but staff had access to specialist advice and support 24 hours a day from SPCT.

We reviewed five DNACPR forms, they were completed according to the National Guidelines.

The chaplaincy service supported families' emotional needs when people were at the end of life.

We found leadership of the end of life service to be good. The SPCT promoted a culture of sharing knowledge and developing the skills of others.

Staff were unaware of the major incident plan and actions to take in the event of a major incident.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement

Overall the services within outpatients and diagnostic imaging services required improvement. Staff were not given post incident feedback, shared learning and changes in practice resulting from incidents.

Completion of children's safeguarding training required improvement in radiography, particularly children's safeguarding. No qualified nursing staff and 17% of unqualified nursing staff had received their appraisal in outpatients. Nursing staff within outpatients demonstrated limited knowledge of the Mental Capacity Act and Deprivation of Liberties. Radiation risk assessments were generic in nature and not fit for purpose. Standardisation of referral forms in radiography was required to avoid confusion with using two different forms. There were regular delays in paediatric reporting.

There was a lack of a clear vision and strategic planning in both outpatients and radiography. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to patient individual needs.

Cannock Chase Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Cannock Chase Hospital

The hospital is not a foundation trust and will not be making an application for foundation trust status.

There Royal Wolverhampton took over the some of the services from Mid Staffordshire NHS Trust. This commenced in November 2014. Cannock Chase Hospital came under the management of the trust. The core services within the report are all the responsibility of the provider.

The level of deprivation in Wolverhampton is higher than the England average. The indicators which have the worst values compared to the England average are: Infant mortality, recorded diabetes, under 18 conceptions, Obese children, Long term unemployment, and children in poverty and excess weight in adults.

We inspected the following core services on offer at the hospital: Urgent & emergency services; Medical Rehabiliation care (including older people's care); Surgery; End of life care; Outpatients & Diagnostic Imaging.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

Detailed findings

There were three experts by experience who were part of the team; they had experience of using services and caring for a person who used services.

How we carried out this inspection

We analysed the information we held about the service, which included national data submissions and information which people had shared with us. In addition to this we reviewed the information the lead inspector had of the service.

We visited the service as part of an announced inspection. The trust had 12 weeks' notice of our inspection start date.

We spoke with patients and visitors and previous users of the service via listening events and specialist groups. We also spoke with staff both clinical and non-clinical staff. We also spoke the executive team about their roles and responsibilities strength and weaknesses of the trust. We spoke to staff individually and in focus groups arranged in advance and one arranged for the same day, as the demand to speak with the inspection team was high.

To reach out ratings we also reviewed documents in use at the time of the inspection and documents sent to us both pre and post the inspection, plus our observations of staff practice.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

We carried out an unannounced inspections between the dates of 08 to 19 June 2015.

Facts and data about Cannock Chase Hospital

Population served:

The Royal Wolverhampton NHS Trust is one of the Acute Trusts in the region. They provide a comprehensive range of district acute and specialist services for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire.

Deprivation:

Wolverhampton is one of the most deprived Local authorities and is in the bottom quintile when compared to other Local authorities. The deprivation in worse than the England average and this can be seen in greater detail on the following slide.

Locations

The hospital has 54 beds and is in Cannock which is in South Staffordshire with the core services of Emergency services, Medicine Rehabilitation, Surgery, End of life Care, Outpatients and diagnostic imaging.

Staff (WTE)

Medical 18.2

Nursing 204.7

Other 227.8

Apr/14 to Mar/15

- Revenue: £468 million
- Full Cost: £464.4 million
- Surplus (deficit): £3.6 million

Activity summary (Acute) Mar/14 to Feb/15

- Cannock Chase Hospital (Nov/14 to Feb/15) 19,728

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Minor injuries unit

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

Information about the service

The Minor Injuries Unit (MIU) at Cannock Chase Hospital is part of the emergency directorate (ED) of the trust. Major injuries and trauma services were situated at New Cross Hospital in Wolverhampton in addition to minor injuries care. The trust was constructing an emergency and urgent care centre on the Wolverhampton site and this was scheduled to open in November 2015. . The MIU was previously managed by Staffordshire and Stoke on Trent Partnership Trust and was transferred to Royal Wolverhampton NHS Trust in March 2015.

Cannock Chase MIU saw around 20,000 patients in the year ending March 2015 including children and adults. The service saw 40 patients on the day before we visited and this was consistent with its daily attendance rate. It opened from 10:30am to 6:30 seven days a week. . The unit had 6.38 whole time equivalent nurse posts for trained as emergency nurse practitioners (ENP). They were supported by two receptionists and an administrator.

The MIU had a small waiting room with toys for children. Behind the reception area, an office and four consulting rooms were located on a corridor. One of the rooms was specifically designed for children. There was also a large resuscitation room with consulting facilities. The unit had facilities for ophthalmic examinations. It did not have access to x ray facilities and refers patient to New Cross Hospital for x ray. The trust provided a regular bus service between the two sites.

Summary of findings

We found that the safety of the service was good, but with some areas that required reviewing.

Staff reported, investigated and learned from incidents. There were systems in use to control infection, safely manage medicines, maintain records and safeguard children and vulnerable adults. Staffing levels were not sufficiently robust to provide the service although this was being addressed by the trust. Some risks to patients were not being properly addressed by the trust such as the lack of access to x ray. Nurses were emergency medicine practitioners (ENP) and this meant they could prescribe drugs. The lead nurse was qualified to care for sick children. No staff however had advanced paediatrics life support training.

We found services required improvements. There was a lack of audit undertaken. The MIU was using nationally agreed protocols to ensure quality of care although there was no system in place to monitor the outcomes for patients. Staff were qualified and had the skills and support they needed to carry out their roles effectively and in line with best practice. The MIU had good joint working with other trust services They referred patients directly to Ear, Nose and Throat, Paediatric and Maternity services.

We found the service was caring. Feedback from people who used the service, those who are close to them and other stakeholders was positive about the way staff treated people. People were treated with dignity,

Minor injuries unit

respect and kindness. The MIU could access a range of emotional support services provided by the trust for patients. The size and layout of the reception area however meant that patients had no privacy in their conversation with the receptionist.

We found services were responsive. The MIU was open seven days a week from 10.30 am to 6.30pm. People could access the right care at the right time except for x ray imaging. Access to care was managed to take account of people's needs, including those with urgent needs or complex conditions such as living with a learning disability. There was no performance information regularly collected to show whether the MIU was performing well or badly on key performance indicators, including waiting times, and other access and flow patient's indicators. Complaints were dealt with in an open and transparent way.

We found leadership of the service to be good. In its Annual Report for 2014/15 the trust said emergency and urgent care (ED) was its first priority for 2015/16. There was little information about how the MIU was to fit into the vision and strategy. ED directorate leaders were visible and available to the MIU and local leaders showed a firm leadership and there was a friendly, open culture of teamwork and concern for patients. The trust and MIU had started to work well on quality issues. However there had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. The trust had not undertaken any comprehensive risk assessment and management plan for the service before or immediately after it had taken it over in March 2015.

We visited the MIU on 4 and 5 June 2015 and spent a total of four hours there. We spoke with two nurses, the lead nurse and the administrator and followed the care and treatment of one patient.

Are minor injuries unit services safe?

Good

Summary

We found safety to be good overall, but with some areas requiring review.

Staffing levels were not sufficiently robust to provide the service although this was being addressed by the trust.

The approach to assessing and managing day-to-day risks to people who used services was focused on clinical risks and did not always take a holistic view of people's needs. The lack of access to X ray equipment was not entered on the risk register and therefore not being monitored and managed by the trust.

The trust had systems in place for staff to report, investigate and learn from incidents, control infection, safely manage medicines, maintain records and safeguard children and vulnerable adults.

The design of the waiting room and reception area represented a risk to the safety of some patients and this had been recognised by the trust.

The unit manager and two other nurses were qualified to care for sick children including emergency care. No staff however had advanced paediatrics life support training.

The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed by the trust. The service has no major incident plan in place.

Incidents

- We found incidents were reported, investigated and lessons learned. Staff working in the MIU reported incidents appropriately. This resulted in changes or planned changes to the service.
- The MIU had recently started to display the lessons learnt from incidents on their noticeboard and nurses were able to give us recent examples of how this had changed their processes and practice.
- We saw that five incidents were recorded on a software system for the MIU. Staff were clear what the process was and could describe it to us.

Minor injuries unit

- Incidents were investigated. We looked at one incident which was a prescription error for a child in May 2015. The resulting report was widely circulated and the independent prescriber and the ED matron based at New Cross Hospital were in the process of investigating it at the time of our visit.
- The matron was responsible for ensuring a consistent approach to incidents across the ED service at New Cross Hospital and the MIU at Cannock Chase and that learning was shared through the monthly Governance Meeting.

Cleanliness, infection control and hygiene

- We found the MIU had responded to the shortfalls found by the trust development authority (TDA) infection prevention audit earlier in 2015 and staff were able to tell us how their practice had improved.
- We noted the MIU was clean and uncluttered in all areas. We saw a cleaning schedule in reception which was up to date. Hand wash, gloves and aprons were easily accessible to staff. Infection prevention information was clearly displayed on a notice board.
- The team had a multipurpose consulting room in which, if necessary, a patient could be isolated to prevent infecting other patients. There was a stock of appropriate protective equipment for caring for a patient with suspected contagious diseases.

Environment and equipment

- We found the MIU lacked important equipment to ensure the safety of patient care. There was no x ray equipment and this meant that the unit could not X ray injuries or fractures.
- Staff estimated that they had to send around 10 per cent of patients to New Cross Hospital in Wolverhampton to be x rayed. This journey could take up to an hour at peak traffic times. The trust provided a regular bus service between the two sites. There were x ray facilities within the Cannock Chase Hospital but no arrangement was in place to enable the MIU to access them. This increased the risk to patients of fractures being missed by MIU staff.
- This risk had not been identified on the unit's nor the emergency department's risk register and was therefore not being managed by the trust.
- Local managers told us that the multipurpose consulting room in the MIU could be adapted to provide an x- ray facility..
- The layout of the waiting room and reception area was not patient friendly or safe. The reception desk was too high for wheelchair users. The height of reception desk also meant that a section of the waiting room was not visible from reception. Staff told us that they were concerned about this, particularly in cases such as attempted suicide or domestic violence.
- Local managers had acknowledged the risks presented by the reception area layout and this appeared on the MIU and emergency department risk register. This risk was managed through a triage system that prioritised patients according to their health needs.
- Equipment was checked and maintained regularly. For example, we looked at the resuscitation trolleys in paediatric and adult areas and the equipment checks were up to date.

Medicines

- The MIU had safe access to appropriate medicines and staff were trained for this. The nurses were non-medical prescribers and had procedures for prescribing, for example for antibiotics.
- Cannock Chase Hospital pharmacy was open at the same time as the MIU from Monday to Friday. The nurses could obtain prescriptions externally any day except Easter Sunday.
- We noted the stock of medicines was limited to those most often required. It was kept locked in the room used for resuscitation and there was a key safe.

Records

- Local leaders told us there was a system in place and the MIU audited its record keeping.
- We checked a sample of two patient records randomly and saw staff had filled them out correctly. We noted staff routinely gave patients a discharge letter, and sent a discharge summary to relevant GPs.

Safeguarding

- The MIU had clear arrangements for safeguarding of vulnerable adults and children, which had been developed with the previous provider trust.
- Policies and procedures were available to staff on managing concerns or the risk of abuse. Staff told us

how they would raise concerns about adults and children at risk of abuse. They said the unit saw a lot of looked after children and needed to make first response referrals.
- All children under six months of age had to be referred, to the paediatrics department at New Cross Hospital.
- The trust was not able to provide us with data on staff training at the MIU as it had recently taken over the service. Staff told us they were booked on the trust's level 3 safeguarding children training from 1 July 2015. This would meet the Royal College of Nursing recommended standard.
- Documents supplied by the trust held no detail regarding adult safeguarding training offered by RWT. However staff confirmed they had undertaken training with the previous provider trust.
- Implementing nurse triage to meet national standards contributed to keeping patients safer. Staff told us that before this system was put in place they saw patients on the basis of what they had reported to the receptionist. This meant there had been risk to patients because it was a first come, first served service.
- Staff told us they made adult safeguarding referrals. The trust had no data on adult safeguarding training for MIU staff as it had recently taken over as the provider.
- The new triage system aimed to identify patient's needs within 15 minutes and meant that anyone at risk of harm could have their treatment escalated and prioritised.
- However, the layout of the waiting room and reception meant that most patients were not completely visible to the receptionist and although this risk was being managed it still limited the extent to which the service could keep patients safe.

Mandatory training

- The MIU staff were not completely up to date with mandatory training. This was because the service had recently been transferred to RWT from another provider trust.
- However, staff showed they had taken training opportunities to enhance patient treatment. For example, they had completed Level 3 (intermediate) paediatric and adult life support training since joining the trust.
- Documents supplied by the trust indicated a target for compliance at both 75% and 95% dependant on the course undertaken.

Assessing and responding to patient risk

- Nurses were emergency medicine practitioners (ENP) and and possessed an additional non-medical prescriber qualification which meant that they could prescribe drugs .
- "Local leaders told us that the CCGs expectation was that unwell patients would be referred to attend either the emergency department at New Cross Hospital or use the Out of Hours GP Service
- Local leaders set up a triage system to establish clinical priorities and avoid this situation.
- The service aimed to see all patients within 15 minutes, so that all problems, whether hidden or visible, could be assessed. The MIU did not monitor patient outcomes. For example, it aimed to triage all patients within 15 minutes, but was not recording whether it met this standard or not.
- Staff knew when to respond to patient risk. The nurses were trained in medical as well as minor injuries issues. This means that they were sufficiently skilled to stabilise a patient with serious illness before transfer.
- The unit manager (and lead nurse) was a registered sick children's nurse and was therefore qualified to care for sick children. Two other nurses had undertaken the emergency care of the child accreditation.
- No staff however had advanced paediatrics life support training. The Royal College of Nursing standards recommend one such trained member of staff should be on duty at all times in a minor injuries unit. Staff were clear about escalation procedures and knew when to ring 999 for an ambulance to take a patient to New Cross Hospital ED.
- There was a CRASH team available within Cannock Chase Hospital that the ENP's could alert to support them with a deteriorating patient if necessary.

Nursing staffing

- There were 6.38 full time equivalent nurse posts when we inspected the service which included the lead nurse. Local leaders told us five nurses were available for work at that time. No agency nurses were being employed at the time and local leaders told us the staff team tried to cover annual leave and any sickness leave.
- The trust told us that staff from the ED at New Cross Hospital were also brought in to assist.

Minor injuries unit

- Two nurses and the manager had been rostered on duty each day to see an average of 40 patients a day between them. However at the time of our visit there were only two nurses on duty one of which was the unit manager.
- Local managers told us the trust was taking steps to ensure that staffing was at a safer level. Further recruitment was in progress to provide to staff the MIU with one triage nurse plus two consulting nurses at any given time.
- A new nurse was due to join in July 2015 and the lead nurse was interviewing candidates to fill a further 44 hours of work. The MIU had also bid for funding to train the new nurse who would join in July 2015 in medication prescribing.
- The staff were located at the MIU and did not rotate to the ED at New Cross Hospital or have a shared rota with ED staff.

Medical Staff

- There were no doctors or consultants working in the MIU, it was nurse led. Patients with major or complex illnesses or conditions had to go to the ED at New Cross Hospital Wolverhampton.

Major incident awareness and training

- Staff were involved in developing an approach to major incidents (Majax) but this was incomplete at the time of the inspection. However specific information was available to them on the ED intranet pages, but was not site specific.
- Cannock Chase Hospital provided security to the MIU in case of any threat to patients or staff. Staff told us security staff arrived quickly if the panic button was activated.

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

Requires improvement

Summary

We found the effectiveness of services required improvement.

The MIU was using protocols to ensure quality of care. However it had participated in little audit activity and was not benefiting from the learning from the College of Emergency Medicine audits that the trust told us it had participated in under the previous provider,or comparison with other urgent care services.

The MIU did not monitor patient all outcomes and could not access information on patients they had to refer to the ED at Wolverhampton New Cross Hospital. This meant they missed opportunities to assess and improve their own practice.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet them. Staff were supported to maintain and further develop their professional skills and experience.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal of their work. Where relevant staff were supported through the process of revalidation of their competence.

The MIU had referral pathways to ensure good joint working with other trust services. They referred patients directly to Ear, Nose and Throat, Paediatric and Maternity services.

Evidence-based care and treatment

- The MIU was using protocols to ensure quality of care. The trust had comprehensive protocols in place for treatments and pathways which were updated in line with evidence.
- The team had put together good practice care pathway protocols it used from its former trust and was planning to share them with The Royal Wolverhampton Trust.
- Staff used good practice guidance to ensure quality. For example, the service had an information board about burns and was also working with a burns network to aim for best practice.
- However, as a small team, the MIU had not participated in much audit activity, other than infection prevention and control with the TDA. As a result, it was missing the opportunity to learn from the College of Emergency Medicine or from comparison with other urgent care services.

Minor injuries unit

- The trust told us that the MIU had been involved in three local audits during 2014/15 under the previous provider trust. The results of these audits could not be made available to us however.
- Local leaders confirmed the MIU had participated in a record keeping audit during 2014.
- The RWT ED had undertaken a number of national audits against CEM and NICE guidelines during 2014/15 before it acquired the MIU.
- At the time of our inspection there was no indication of how the resulting action plans from these audits would be shared with the MIU going forward.

Pain relief

- We observed staff offering patients pain relief appropriately. We saw a chart in the paediatric room for 'Recognition and assessment of acute pain in children'. It was an adapted pain assessment score diagram.

Nutrition and hydration

- There were a hot drinks and a cold water machine in the outer waiting area.
- Restaurant facilities were in the Hospital.

Patient outcomes

- The trust told us the MIU monitored unplanned re-attendances so it could learn from this effectiveness indicator.

Competent staff

- All of the nurses were qualified emergency nurse practitioners (ENP) or emergency care practitioners.
- Staff realised the importance of maintaining and developing their skills. They had for example, demonstrated their competence by successfully resuscitating four patients in the year ending March 2015. They were anticipating undertaking advanced life support training at the time of our inspection.
- The unit manager (and lead nurse) was qualified to care for sick children. Two further nurses had emergency child care training. No staff had advanced paediatrics life support training and this too was planned.
- Since joining RWT, staff had accessed the trust's training on-line and face to face.
- The lead nurse had given all her staff appraisals in advance of joining the new trust and was planning the next round of appraisal meetings although we found the trust held no data on this.
- Staff had not received any dementia awareness training.

Multidisciplinary working

- The MIU had referral pathways to ensure good joint working with other trust services. They referred directly to Ear, Nose and Throat, Paediatric and Maternity services. In the case of serious illness related to circulation and or breathing, they could refer directly to the Heart and Lung department at New Cross Hospital.
- The service was consistently patient centred and responded to increases in demand.

Seven-day services

- The MIU was open for seven days a week from 10:30 to 18:30. Hours of opening had been reduced from 08:00 to 00:00 on 1st December 2014 under the previous provider trust.

Access to information

- Access to information was constrained by the MIU's current computer system. This meant that the service could not easily track patients or outcomes for patients who had been sent to New Cross Hospital. This lack of feedback meant they were missing an opportunity to assess and improve their own practice. Staff told us this computer system was to be phased out during 2016.
- Staff felt positive about the trust's Intranet facility. Although staff were still familiarising themselves with it, they told us it was a good store of information and they knew where to find what they needed to know.
- We noted staff ensured that they had relevant information on patients and protocols. They arrived at work at 09:00 in advance of the MIU opening time of 10:30. They found the trust's protocols easy to access on the IT system and the administrator helped by printing off relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- MIU nurses discussed what they were doing with patients and gained their agreement to treatment. For example, we observed a nurse explaining the new

government guidelines for tetanus immunisation to a patient. She also asked explicitly for consent to give an injection. Nurses used a triage form with a box to record patient's consent.
- Staff in the MIU told us they undertook Mental Capacity Act training when they were employed by the previous provider trust.

Are minor injuries unit services caring?

Good

Summary

We found the service was caring.

Feedback from people who used the service, those who are close to them and other stakeholders was positive about the way staff treated people.

People were treated with dignity, respect and kindness during all interactions with staff. Written information was made available to patients about their conditions.

The size and layout of the reception area meant that patients had no privacy in their conversation with the receptionist.

The MIU could access a range of emotional support services provided by the trust for patients.

Compassionate care

- . At the time the Trust was not able to provide us with any data from the Family and Friends Test (FFT) for the MIU as the FFT process had only been introduced for such services in April 2015'
- We noted that there were no posters on display. The unit manager showed us a package of posters that had arrived from the trust just the day before our visit and were waiting to go on display. They said that staff try to give a few patients each day an FFT card to complete.
- We observed MIU nurses speaking to patients in a calm and compassionate manner.
- The waiting room was small. We sat in reception to see if patient's conversations were private. We found that the restricted space and the position of the reception area meant that waiting patients could overhear private conversations with the receptionist (we have addressed this shortfall under the safety domain).
- Staff told us that this may have contributed recently to the reluctance of a young patient to disclose, at the earliest opportunity, that they had taken an overdose of drugs.

Understanding and involvement of patients and those close to them

- We observed that the patient whose care we followed through their triage, consultation and treatment at the unit was given information by staff during each stage to help them understand their treatment and condition.

Emotional support

- The MIU was staffed by experienced nurses who were able to offer emotional support if needed.
- ED leaders told us if there were other requirements the MIU had access to the trust bereavement service, chaplaincy service, PALS, psychiatric services, social workers, safeguarding services and alcohol / drug liaison service.

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

Good

Summary

We found services were responsive.

The MIU was open seven days a week from 10.30 am to 6.30pm. People could access the right care at the right time except for x ray imaging.

Access to care was managed to take account of people's needs, including those with urgent or needs or complex conditions. The MIU could refer patients directly to specialities if necessary, bypassing the ED at New Cross Hospital.

The size and layout of the waiting room meant that sometimes people could not wait in comfort.

There was no performance dashboard to show whether the MIU was performing well or badly on key performance indicators, including waiting times, and other access.flow and outcome indicators.

Minor injuries unit

There was openness and transparency in how complaints were dealt with. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The opening times of the MIU had been reduced six months prior to our inspection when it was provided by another trust. It still opened seven days a week. The RWT told us these times were under review again. Following our inspection the decision was made to not change the opening times.
- The MIU did not fully meet the needs of local people because it had no x ray facilities. Staff estimated that this affected around 10 per cent of patients. The staff used evidence based tools to establish whether an x ray was necessary. If so, patients had the inconvenience of travelling to New Cross Hospital to have an x ray.
- The waiting room was too small for patient's needs. The service saw around 40 people a day and often people arrived with friends or family. We observed that the waiting area was already crowded at 10:30am when the service opened.
- Patients had to stand while talking to the receptionist. The reception desk was too high for the receptionist to check on patients or to see into a pushchair. It was too high for wheelchair users.
- However, staff had made the most of the limited space available in the MIU. There was a room to carry out eye examinations, with guidelines and charts, and a specific room for children. There were also resuscitation facilities.

Meeting people's individual needs

- We observed that staff had a 'person centred' approach to dealing with patients.
- Staff recognised when patients needed additional support to help them understand their care. Two of the nurses had gained sign language skills. They used a communication tool for patients with learning disabilities. They said they had access to an interpreter if needed.
- Staff gave us an example of how they escalated patients through triage if they had learning disabilities or mental ill health and were not coping with waiting.
- There was no specific protocol in place for supporting patients with dementia through their treatment at the MIU.
- The MIU had adapted services for different types of patients in some cases. Two of the nurses were qualified in sign language. They used a communication book for patients with learning difficulties.
- Staff were also sensitive to the needs of patients with dementia and had important information on their noticeboard for dementia carers. However, they had not had formal dementia training.
- Opening times were clearly displayed in large print outside the waiting room.
- There was a screen in the waiting room which indicated to patients how long they were likely to have to wait before being seen.
- We saw leaflets on display in the consulting rooms which nurses could give to patients to help them understand various conditions. However, these were not freely available in reception and were not available in languages and formats other than written English.

Access and flow

- Although staff could tell us how long certain patients had waited, there was no performance dashboard to show whether the MIU was performing well or badly on key performance indicators, including waiting times, and other access and flow indicators.
- The MIU could refer patients directly to specialities if necessary, bypassing the ED at New Cross Hospital. There was no data available to check how efficiently this worked.
- Patients could be transferred to the ED at New Cross Hospital from the MIU by 999 ambulance if their condition required. This could be on code 'red' status-eight minutes to ambulance arrival at the MIU.
- We asked to see records of the last three transfers. The records noted the time that the patient arrived at the MIU and that the ambulance arrived. However there was no means for the MIU to track through the arrival time and time to treatment at the ED.

Learning from complaints and concerns

- Large photographs with the names of the local leaders were displayed clearly in the external waiting area so patients were informed who was in charge of the service.

Minor injuries unit

- PALs leaflets were available for patients and clearly displayed.
- We saw on the notice board in the office of the MIU the same 'shared learning' display that we had seen in the staff room at the ED in New Cross Hospital. It included, lessons learned, compliments and complaints trust wide in the emergency services department.
- The lead nurse who managed the MIU confirmed that learning from complaints was discussed at the monthly emergency department Governance meeting. This was attended also by the matron who oversaw the MIU, and who monitored and supported change through learning at monthly supervision meetings with the lead nurse.
- Staff said they dealt with any complaints as soon as possible. They told us patients used these feedback mechanisms to communicate their frustration about the lack of x ray facilities.

Are minor injuries unit services well-led?

Good

Summary

We found leadership of the service to be good overall, but with some areas requiring review.

The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. The service had an incomplete picture of patient experience, outcomes and its own effectiveness.

The trust had undertaken a due diligence assessment before taking over the unit but some significant risks had not been identified. There was no comprehensive management plan for addressing the the weakneses identified in the service after it had taken it over.

Risks issues were not always dealt with appropriately or in a timely way. The risks and issues described by staff did not correspond to those reported to and understood by leaders.

The trust declared in its Annual Report and Quality Account for 2014/15 that emergency and urgent care was its first priority for 2015/16. The MIU had been taken on by The RWT since 1 March 2015 and there was little information about how it was to fit in the vision and strategy for the ED.

However, the trust and MIU had started to work well on quality issues. Local leaders attended the ED Governance meeting on a monthly basis where managers discussed risks and learning from complaints and incidents.

ED directorate leaders were visible and available to the MIU and local leaders showed a firm leadership. The MIU demonstrated a friendly, open culture of teamwork and concern for patients.

Patients were encouraged to give feedback about the service and staff were able to influence the planning and deliver of care in the MIU. However, they had not been involved in the trust's wider plans for Urgent Care.

Although the trust had identified emergency and urgent care services as its first priority for 2015/16 there was little information available to staff or the local population about the MIU's sustainability or about how it would develop within the broader plan.

Vision and strategy for this service

- The trust declared in its Annual Report and Quality Account for 2014/15 that emergency and urgent care was its first priority for 2015/16.
- The MIU at Cannock Chase Hospital had been taken on by The RWT since 1 March 2015. Before this it was provided by an independent healthcare provider within Cannock Chase Hospital, which was provided until November 2014, by Mid Staffordshire NHS Hospital Trust.
- The 2014/15 Annual Report says little specifically about plans for the MIU except that its opening hours will change to 10am to 7pm Monday to Sunday in 'the future'. However since the inspection the decision had been reached to not extend the hours.
- The trust had not effectively communicated a clear vision for this service. Staff reported that senior leaders were in frequent contact and they could ask them any questions. The staff understood that they would be part of a 'hub and spoke' service with the new Emergency and Urgent Care Centre at Wolverhampton when it opened, but the Trust had not developed the detail.

Minor injuries unit

- However, staff were pleased with the recent transfer of the MIU to the Royal Wolverhampton Trust and the fact that they had listened to them and were supportive of their staffing needs.
- ED directorate leaders were visible to staff and patients at the MIU.

Governance, risk management and quality measurement

- The MIU had been brought into the Governance structure for the ED
- There were few arrangement in place at the time of our inspection to support continuous improvement in the MIU. It did not have a performance dashboard or systems to monitor outcomes for patients..
- A new triage system had been put in place but there was no way the trust could assess the benefits to patients.
- There was no means of tracking or auditing ambulance response and arrival times for transfers to the ED at New Cross Hospital. As a result, the service had an incomplete picture of patient experience, outcomes and its own effectiveness.
- The MIU was waiting for the trust and the CCG to clarify which performance indicators they wanted to measure.
- Although the trust and emergency services department had systems in place, risk management for the MIU was not yet effective. The trust had undertaken due diligence risk assessment for the service in January 2015 before it had taken it over. Some risks were not identified and we saw no eveidence of a clear plan for addressing all the weaknesses that were identified.
- The lack of x ray access was a significant risk to patients, but this risk was not acknowledged on the unit or the directorate risk registers and was therefore not assessed or managed. The MIU was still awaiting a decision on the x- ray equipment issue when we visited.
- The trust had also assessed visibility in reception as a yellow risk, which did not fully reflect the hazard.
- The MIU's role in major incidents was not developed. It did not have a Majax protocol or policy.
- However, the trust and MIU had started to work well on quality issues. The MIU lead nurse attended an emergency department Governance meeting on a monthly basis where managers discussed risks and learning from complaints and incidents.
- MIU staff were proactive in identifying relevant trust policies, for example, infection prevention, on the website.
- Local leaders told us the trust had supported improved staffing levels in the MIU.

Leadership and culture of service

- The service was overseen by the emergency services clinical lead for the trust and a matron, both based at the ED at New Cross Hospital Wolverhampton.
- Local leaders confirmed that they had monthly meetings with the matron since the MIU had been provided by the RWT.
- Local leaders showed a firm leadership of the MIU and staff said they felt well supported. They were committed to providing a good quality service for the local population, encouraged specialist training and a flexible attitude toward staff rotating work with the ED to learn and improve and share their knowledge.
- The MIU also demonstrated a friendly, open culture of teamwork and concern for patients.

Public and Staff Engagement

- The MIU gathered public views and acted on informal as well as formal feedback. The lead nurse was proactive in giving out Friends and Family test cards to patients on a daily basis.
- Staff were able to influence the planning and deliver of care in the MIU. However, they said they had not been involved in the trust's wider plans for Urgent Care.

Innovation, improvement and sustainability

- The MIU had very recently been taken over by RWT. Staff told us they were keen to promote and develop their service at Cannock Chase Hospital as part of the new emergency and urgent care services configuration within the trust.
- However at the time of our inspection, they had little information about how that would develop. . The lack of vision for the MIU was having an impact on assessment of the service's sustainability.

Medical care (including older people's care)

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

Information about the service

Rehabilitation medical care is provided at Fairoak Ward at Cannock Chase Hospital. This is a 27 bedded ward providing care and rehabilitation predominately for older people.

During the inspection we spoke with 14 patients including family members and visitors. We spoke with 10 members of staff including nurses, therapists, medical staff and non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records. We held focus groups that were attended by medical care staff. We also visited the ward during an unannounced inspection 18 June 2015.

Until November 2014 Fairoak Ward was part of Mid Staffordshire NHS Foundation Trust (MSFT). MSFT has undergone dissolution with transfer of responsibilities for some services (including Fairoak Ward) to Royal Wolverhampton NHS Trust (RWT). Prior to the dissolution, the services at Cannock Chase Hospital had been the subjected to much external scrutiny for assurance of safety and sustainability and now have undergone a complete change in management. It is through this context that the findings should be viewed. Information prior to November 2014 has not been included in our assessment of the service.

Summary of findings

The overall rating of this service is that it requires improvement.

The ward's track record on safety showed that improvements were required to protect patients from harm. There were many patients falling and some had sustained harm. Some poor infection control practices were seen during the inspection.

Lessons were learnt when things had gone wrong but improvements were still on-going. Staff had not received duty of candour training and there was no evidence to suggest that this was being met.

There were systems, processes and practices in place to keep patients safe but they were not always reliable. Out of date medicines including insulin was being stored in the medication refrigerator on the ward. Checks on feeding equipment were found not to be up to date with required portable appliance testing (PAT).

Risks to patients using the services were assessed and their safety monitored but the maintenance of these were fragile. The ward was covering their own nursing staffing shortfalls on a continual basis with limited access to bank or agency cover which was unsustainable. Staff felt that reporting when they were short staffed was discouraged.

Medical care (including older people's care)

Risks to the service were anticipated and planned for but these were at ward level and were not always linked with the rest of the trust. Beds were broken on the ward and had not been repaired or available for patients in a timely manner.

Patients' needs were assessed and basic nursing provided but care and treatment were not always delivered in line with standards and evidence based guidance. The documentation of wound care was not consistent and did not clearly state how the wound was to be managed.

Key outcomes show that the length of patients stay and the readmission rates were higher than expected. However, key performance data to monitor effectiveness regarding management of complex discharge planning was collected.

Patient consent to treatment was sought but the awareness regarding legislation required strengthening and improving.

Staff did have skills, knowledge and experience to deliver effective care and treatment. Multidisciplinary (MDT) working was evident.

Overall we found that patients were treated with kindness, dignity, respect and compassion on Fairoak Ward. Patients and those close to them were involved in decisions about their care particularly in relation to discharge planning.

Patients concerns and complaints were listened to and resolved locally and there was a very low number of formal complaints. However there was no evidence of using this information to improve the quality of care.

Patients could access care and treatment in a timely way; however staff were concerned about patients being transferred to the ward overnight.

There was not a clear shared vision at ward level. The nursing staff appeared to be isolated managerially, operationally and professionally and were not able to provide improvements to the service. The local leadership required time, capacity and support in order to promote good quality care and ensure that services could be continuously improved.

The governance framework was present at directorate level but not fully engaged with at ward level. This meant that any concerns regarding Fairoak Ward may not always be raised formally and key safety and governance messages may not always be shared directly.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall we judged this domain as requiring improvement in order to provide assurance of safety consistently.

The ward's track record on safety showed that improvements were required to protect patients from harm. Occasionally patients would fall and some had sustained harm. Some poor infection control practices were seen during this inspection..

Lesson were learned when things had gone wrong but improvements were still on-going. Staff had not received duty of candour training and there was no evidence to suggest that this was being met.

There were systems, processes and practices in place to keep patients safe but they were not always reliable. Out of date medicines including insulin were being stored in the medication refrigerator on the ward. Feeding equipment was found not to be up to date with portable appliance testing (PAT).

Risks to patients using the services were assessed and their safety monitored but the maintenance of these were fragile. The ward was covering their own nursing staffing shortfalls on a continual basis with limited access to agency cover using bank staff as preferable this was unsustainable. Staff felt that reporting when they were short staffed was discouraged.

Risks to the service were anticipated and planned for but these were at ward level and did not always link with the rest of the trust. Beds were broken on the ward and were not repaired in a timely manner so they were available for patients.

Incidents

- Fairoak Ward had not reported any 'never events' (serious, largely preventable patient safety incidents).
- Two patients had recently fallen and sustained harm. These were classed as serious incidents and were subject to investigations to find the root cause and identify actions required to reduce the reoccurrence. The response to the incidents had been proportionate and the investigation started immediately. Initial findings following the second serious incident showed that the dependency of patients throughout the ward at the time of the fall was not met by the staffing which was below establishment (one trained nurse less). In order to counter this shortfall a Health Care Assistant had covered the shift however this staff member was required to escort a patient to New Cross Hospital for an urgent MRI scan and was off the ward for seven hours.
- There was an electronic incident reporting system for reporting incidents and near misses available to the ward. This was a new system for the team following transition to Royal Wolverhampton NHS Trust (RWT). The ward manager had received training in order to update incident investigations on the system. A member of the governance team attended a ward meeting to demonstrate it to the team. Staff told us they had used the system to report incidents and received feedback from the ward manager when they had done so.
- Patient falls was the highest category of incident that the ward report, with 66% of reported incidents in six months (November 2014 to April 2015) being falls related.
- Incident reporting data showed that incidents were being investigated in a timely manner by the ward manager and staff were provided with feedback.
- Staff told us that they felt reporting incidence of staff shortages was discouraged. Incident reporting data shows that staff reported when the bank/agency was unable to cover a shift on two occasions in the six months period from November 2014 to April 2015.
- Mortality and morbidity meetings for care of the elderly directorate within Royal Wolverhampton NHS Trust (RWT) had taken place monthly to share feedback, highlight any suboptimal care and share lessons learned.
- Staff did not demonstrate a clear understanding of the duty of candour and said that they had not received any training regarding this. There was evidence of staff informing patient relatives regarding the falls that had resulted in harm but this did not include other requirements of the regulation such as offering to share the investigation.

Safety thermometer

Medical care (including older people's care)

- The safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The data indicated that the ward had not always met the target of 95%; scoring less than 95% (81-88%) for two out of the last six months (December 2014 - May 2015). The issues highlighted by the audit were falls, tissue viability (pressure ulcers acquired on the ward) and patients with catheters that required treatment for urinary tract infections. Key areas relating to the safety thermometer were on display on the ward particularly, falls prevention.
- Two ward bays were used for patients identified as at high risk of falls as they offered higher levels of visibility. During the unannounced inspection a member of staff remained in these bay areas to observe patients closely.
- We found completed risk assessments regarding falls and use of bed rails in patient's bedside care records.
- Patients assessed to be at high risk of falls were identified by a yellow triangle symbol being present above their beds and on the main wipe board.
- A falls action plan for Fairoak Ward for May to September 2016 was on display in the ward manager's office; progress was RAG (Red Amber Green) rated and there were no red items. Areas that were highlighted as on-going actions for patient at high risk of falls included; hourly (rather than two hourly) comfort rounds to check patients and to commence daily safety briefing for all staff at the start for each shift, to highlight any patients at risk on the ward. Patients being at high risk of falling on Fairoak Ward was also documented on the directorates risk register.
- Nursing staff were seen carrying the falls alert bleeps. These are linked to pressure sensors that alert staff that a patient at high risk of falls may be about to mobilise independently. There were two of these in use for the ward.

Cleanliness, infection control and hygiene

- Estates improvement works were on-going throughout the ward. Despite this, the area including patients shower rooms and toilets, were visibly clean and generally tidy with enough storage space.
- Equipment had tags in place which were colour coded to indicate the frequency of cleaning that was required. These tags were dated, when they were last cleaned and were found to be generally up to date.
- Cleaning schedules were not seen in use on the ward and the ward manager confirmed that they had been advised to remove them. However they planned to reinstate them in order to provide assurance of regular cleaning of the ward.
- The audits conducted looking specifically at the cleanliness standards on the wards show variable results from 47% in March 2015 to 95% achieved in May 2015. Some of the lower scores were as a result of areas in need of refurbishment e.g. the dirty utility room to which work had since taken place.
- Hand washing facilities were positioned throughout the ward and a variety of hand wash and cleansing gels were available.
- Staff were seen to comply with the 'bare below the elbow' infection control policy and made use of personal protective equipment (PPE) including aprons and gloves. We noted in documents June 2015 when a staff member had not complied with the 'bare below the elbow' policy, they had received feedback regarding this during the hand washing audit.
- Some poor practice was witnessed regarding infection control, particularly carrying used linen to the dirty utility in gloved hands rather than in a linen bag. This appeared to be usual practice and all grades of staff were witnessed doing this. This has been shared with the ward manager who said that this would be monitored. This is contrary to the findings of on-going audits which show exemplary performance in hand hygiene.
- 90% of eligible ward staff had completed training in infection prevention level two by May 2015.
- The ward completed monthly 'Saving Lives' audits to; prevent microbial contamination, assess on-going care of peripheral venous cannulas and on-going care of urinary catheters. All results since November 2014 have been 100%.
- There have not been any norovirus outbreaks, reportable incidence of c. difficille or MRSA bacteraemia on the ward since November 2014.

Medical care (including older people's care)

Environment and equipment

- Refurbishment works were on-going throughout the ward including; improving the storage rooms, improving the visibility from the nursing station for monitoring patients and a new reception area. Staff told us they were pleased that the ward was having much needed refurbishment.
- Emergency resuscitation equipment was clean and available on the ward. The access to the resuscitation trolley was sealed for security but there was evidence of frequent checking on a daily and weekly basis. The defibrillator print outs showed that the machine was being checked daily. When we went back to the ward unannounced we found that the defibrillator had been consistently checked since this time.
- We found that a broken bed was unable to be used by patients and this had been the case for over two weeks. The ward clerk showed us logs on the computer of two occasions following the initial report to estates, when progress had been chased. A new part was awaited. During the unannounced ward visit it was found that this bed remained out of use and also two others were now broken. The ward manager was aware and had informed the matron. An engineer arrived to fix the beds during our unannounced inspection. We were concerned that having the broken beds was causing delays to patients awaiting transfer to the ward; however the ward manager said they did not have any patients waiting for a place on Fairoak Ward presently.
- All the nutrition feeding equipment pumps were found not to be up to date with portable appliance testing (PAT) but were available in the store cupboard to be used. This was brought to the ward manager's attention and they said they would arrange for them to be tested. However during the unannounced inspection while there was evidence that one of the pumps had been checked, another four that required testing remained in the cupboard. The ward manager could not explain why they had not all been checked and removed them immediately to arrange for them to be collected for testing.
- There appeared to be sufficient equipment to assist staff with moving and handling of patients and a patient hoist was seen in use.
- Pressure ulcer prevention mattresses were in appropriate use on the ward. Staff did not voice any concerns about shortages or access to any type of equipment they required for the patients on the ward.
- Call bells were available in each patient bed space and had been placed where they could be accessed by the patients.

Medicines

- We observed that the medicine storage room door would not close and lock. A second store room used to store some prescribed medicines had no lock. We found medicines and intravenous fluids inside both store rooms which were not securely stored in locked cupboards. On informing a member of staff about the poor medication security they asked the maintenance team to mend the medicine storage room door, which was completed during the inspection. However, the second store room remained unlocked. During the unannounced inspection it was found that medicines were all stored securely apart from the medicines refrigerator.
- The medicine refrigerator temperature was checked regularly to ensure that contents were stored correctly. The refrigerator however was unlocked and was found to contain ; two items past expiry dates which included insulin, four items relating to patients that were no longer on the ward and inappropriate storage of opened insulin vials. This put patients at risk of receiving unsafe or ineffective medicines. This was brought to the attention of the both the ward manager and the trust management team. The response was rapid and professional; not only ensuring that the rest of the medicines storage in the ward was appropriate but also conducted checks of medicine refrigerators throughout the whole trust. It appeared to be an isolated incident. The trust planned for the pharmacy team to spot check refrigerators on at least a monthly basis.
- Controlled drugs were stored securely in a separate locked cupboard and were checked three times a day and records we saw showed that this was undertaken. There were arrangements to store and administer controlled drugs including patients own and stock balances of controlled drugs were correct.
- Nursing staff did not wear 'do not disturb tabards' whilst administering medicines to patients. The ward manager

confirmed that 'do not disturb tabards' were available on the ward but none of the staff used them. This meant the nurses were not following best practice for safe administration of medicines.

- We checked five patient's prescription charts and found minimal discrepancies. Patient's allergy status was found to be complete and reasons why medicines were not administered was recorded on four of the charts.

Records

- Medical care records were contained in paper files and were legible, dated and with the name of the doctor who had completed the record.
- Nursing care records were kept with the medical notes. We saw that nurses documented and evaluated care on a shift by shift basis. Patient's daily care charts such as records of change of position and food and drinks provided were in paper format and were kept at the patient's bedside.
- Patient's care records were kept securely in notes trolleys on the ward area and they were found to be well organised. The care records we looked at were chronological with clearly signed and dated entries.
- 100% of eligible ward staff had completed health records training by May 2015.
- Risk assessments were completed including; nutrition, falls, use of bedside rails, and pressure ulcer prevention. However we found that it was unclear from the documentation what the plans were for patients that had wounds. We found inconsistencies relating to various types of wounds including, pressure ulcers, leg ulcers and a surgical wound. For example dressing changes were documented to be required at 72 hours but were not changed for five days on one occasion. Staple removal from a surgical wound was also not documented (it was documented that half of the staples had been removed previously). A nurse reassured us that the rest of the staples had been removed and but had not been documented. The documentation did not support clear wound management planning, this meant that patient's wounds may not be dressed or assessed at the correct frequency to facilitate healing. Core care plans for inpatients wounds, developed by the trust (RWT -Handbook of Wound Management July 2013) were not in use.
- Nurse handover sheets were printed from the computer and contained full names of patients increasing the risk of information governance breach; however confidential waste bins were available for staff to dispose of the sheets. Posters reminding staff to dispose of handover sheets prior to leaving the ward were prominently displayed on the exit door.

Safeguarding

- Overall the ward staff demonstrated an awareness of adult safeguarding principles. One nurse described an occasion when they suspected a patient was being financially abused which was taken seriously and escalated appropriately.
- The ward team were not compliant with the trust's children's safeguarding training target (75%) with 41.1% achieved in April 2015. The ward manager was addressing this and expected all staff to be trained by September 2015.

Mandatory training

- The mandatory training subjects included: fire safety, infection control, basic life support, moving and handling, information governance, bullying and harassment, and health record training.
- The ward manager explained that compliance with mandatory training had been affected by the transition to RWT as the framework/training was different. For example the manual handling key trainer for Fairoak Ward has encountered delays to undertake the trust's training in order to cascade this to the ward staff. This has resulted in manual handling training compliance rate of 45% in May 2015 whereas the trust target is 75%.
- Other areas yet to meet compliance targets included; safeguarding children (41.1%) and basic life support (BLS) for Health Care Assistants (12%). The ward manager had requested stand-alone training sessions at Fairoak Ward to facilitate compliance.
- Despite challenges, the records demonstrated month on month improvement in mandatory training compliance the majority within trust targets in a relatively short period of time, for example infection prevention level 2 (95% meeting trust target) and health records training (100% exceeding the trust target of 95%).

- All eligible staff were up to date with the blood transfusion training and competencies to facilitate safe blood transfusion on the ward.
- Ward nursing staff told us that the ward manager ensured they completed all their mandatory training and would remind staff on an individual and team basis.
- Staff told us that they were not provided time to undertake mandatory training and it was expected to be done in their own time with no recompense.

Assessing and responding to patient risk

- We observed a nurse handover which took place on the ward. Relevant information was provided including action to be noted for the oncoming members of staff. Patients were referred to in a respectful manner. All of the oncoming shift team received the handover. This meant that all of the nursing staff were aware all of the patients on the ward and their current condition.
- The falls action plan for the ward had highlighted that handover time was a period of reduced contact time for patients. During the handover a member of the team was seen to continue to observe the patients who were at risk of falling, in case assistance was required.
- The ward does not have an electronic observation management system like the one in use at New Cross Hospital, but used a paper based observation chart which incorporated an early warning scoring system to highlight patients at risk of clinical deterioration.
- Trust policy (CP05) stated that in the event of a patient's sudden deterioration at Cannock Chase Hospital they were to be reviewed by a consultant and transferred to New Cross Hospital via a paramedic crewed ambulance and staff were aware of this.
- On each shift a trained member of nursing staff from the wards at Cannock Chase Hospital carried a bleep to respond to any cardiac arrest calls. All trained nurses had competed BLS level 3 to carry the crash bleep which was in line with trust policy. Staff may hold other qualifications for example a member of staff told us that they did not mind taking the bleep because they had completed an Intermediate Life Support (ILS) course in a previous post. There was also a hospital coordinator bleep which was usually carried by a band seven nurse from the ward with the main responsibilities being fire warden and responding to any staff concerns. The rota for the cardiac arrest and hospital coordinator bleeps were managed by the theatre manager at Cannock Chase Hospital. There were on average one - two calls per month according to the records but were panic attacks, falls and faints, not cardiac arrests.
- The ward manager said that there was a danger that they would be asked to take more acutely unwell medical patients which they were not resourced for, for example a patient recently required a long term vascular access (a catheter that is inserted into the central venous system). This meant staff from New Cross Hospital had to come to the ward to administer the patient's intravenous antibiotics through the line. The ward manager was concerned the nursing staff were caring for a patient for which they had little experience or expertise. As this was a one-off occurrence further training had not been arranged and it was not documented on the risk register.

Nursing staffing

- The names of the nursing staff on duty for the day were displayed on a wipe board on the ward, however the number of planned versus actual staff on duty for each shift was not identified. This was contrary to trust policy.
- The ward staffing establishment had been set prior to the transition to the RWT. The safer staffing audit to check staffing levels matched patient dependency was planned for July 2015.
- The ward used an electronic rostering system to manage staffing rotas.
- There was a low turnover of staff and vacancy rate was consistently low (1%). However the level of sickness absence was rising (6.9% in May 2015) with at least three staff on long term sick. There was also maternity leave to cover.
- The staffing data published by the trust show that the average rate that trained staff numbers met the planned level of staff was around 90% for the four months (January to April 2015), and for health care assistants the fill rate was greater than 95%. This was reflected in the rotas on the ward.
- Despite these figures, staffing was consistently the greatest source of stress for all the ward staff. Staff told us that they were not allowed to access agency staff. When shifts were not covered they accessed their own

staff or bank nurses. Unfortunately they found that since joining the trust they were rarely able to cover the shortfall with bank staff so had been covering their own shortfall and the ward team had been doing extra hours and shifts as bank staff since November 2014. The ward manager, who was meant to be supervisory (managerial and not counted in the shift numbers), also worked on the ward covering shortages of trained and untrained staff. The staffing records showed that in May 2015 for example, the ward manager covered 19 clinical shifts. Nursing staff often worked extra shifts on their days off. A staff nurse told us that she had worked four shifts in her annual leave the previous week to cover the ward. A more sustainable staffing solution was urgently required as this could lead to more staff sickness and affect the ability to provide safe patient care.

- Staff told us that they felt under pressure due to staff shortages and one trained nurse could be responsible for up to 15 patients. This exceeds the Royal College of Nursing (RCN) recommended trained nurse to patient ratio of one to seven for older person wards. During the inspection the staffing numbers were within the recommended ratios however on the afternoon shift there was to be two trained nursing staff for 23 patients. At the unannounced inspection the trained nurse numbers were above the planned levels (five instead of four), with the ward manager making up a shortfall of one health care assistant.
- Evidence of using health care assistants (HCA) to boost overall numbers of nursing staff on duty was confirmed in the trusts safer staffing data in January and April 2015 figures showing that more HCA's were on duty than planned numbers.
- Staff felt that reporting of staff shortages was discouraged; however the ward manager informed us that staffing shortages were escalated to matron. This meant that the organisation may not be sighted on the risks related to safe staffing of the ward.
- Providing nurse escorts for patients undergoing urgent Magnetic Resonance Imaging (MRI) and other scans to New Cross Hospital was also depleting shift cover. Inspectors were aware on two ward visits that staff were on escort duty at the time. Health care support workers usually accompanied the patients rather than trained nurses.

Medical staffing

- Consultant led medical care was provided on Fairoak Ward with four consultant ward rounds and a multidisciplinary team (MDT) meeting taking place each week.
- There were two consultants who provided cover between them to ensure that there was a senior doctor available for the ward.
- Weekend consultant advice was available via the telephone.
- Out of Hours cover (weekend and nights) was provided for the Cannock Chase Hospital by an on-call doctor (Senior House Officer or Registrar level) who was based on site.
- A senior anaesthetist was also available on-call to attend all emergency calls e.g. cardiac arrest bleeps. The trust informed us that this was a new arrangement since November 2014.
- Medical staff told us that there was a system for handover to the on-call doctor and showed us that there was a shared file on the computer where handover details and patient lists were securely stored.
- The trust confirmed that two named full time locum SHO doctors had been employed at Cannock Chase Hospital since February 2015.
- All the nursing staff that we spoke with were happy with the level of medical cover during the day and out of hours and had not experienced delays when requiring urgent medical advice for patients.

Major incident awareness and training

- Staff showed a general awareness of major incident procedures and were aware of what to do in the event of a fire. A fire risk assessment approved by the trusts fire safety group was documented on the risk register.
- Emergency plans and evacuation procedures were in place and on display. Staff were trained in how to respond to fire and evacuation procedures, 92% of ward staff had completed their fire safety mandatory training by May 2015.
- The two fire exits on the ward were checked during the inspection and were found to be closed and clear of any obstructions.

Medical care (including older people's care)

- The hospital coordinator bleep holder had responsibilities as fire warden for Cannock Chase Hospital and this was always carried by a senior nurse via a rota system.
- Major incident/ Business continuity plans for Cannock Chase Hospital have been requested from the trust.

Are medical care services effective?

Good

Overall we judged this service as good.

Patients' needs were assessed and basic nursing provided and delivered in line with standards and evidence based guidance. For example we saw that comfort rounds were undertaken appropriately. We noted that assessments were completed for patients to ensure staff were aware of risks.

Nursing staff told us they felt less confident about the new policies and paperwork following the transition to the Royal Wolverhampton NHS Trust.

Key performance data to monitor effectiveness regarding management of complex discharge planning was collected.

Patient consent to treatment was sought but the awareness regarding legislation required strengthening.

Staff had skills, knowledge and experience to deliver effective care and treatment and multidisciplinary working was evident.

Staff had access to relevant information they needed to deliver effective care and treatment.

Evidence-based care and treatment

- Due to the transition of services from Mid Staffordshire NHS Foundation Trust to the Royal Wolverhampton NHS Trust in November 2014; all of the local policies, procedures and associated assessments and documentation were transferred too. Nursing staff told us they felt less confident about the new policies and paperwork and did not receive enough support with this changeover. There is evidence of some planned support from infection control services with the transition.
- Intervention comfort charts were used to indicate at the bedside when a patient had been offered assistance to change position and were safe and comfortable. These were completed according to the patient's fall and pressure ulcer prevention risk assessments and we saw evidence that they were undertaken usually every two hours.
- There was evidence of appropriate referral to Tissue Viability Nurse for assessment.

Pain relief

- Patients and their relatives told us that pain relief was offered and provided if required.
- Nursing staff were seen to ask regularly if a patient was comfortable and offer pain relief on medication rounds on the ward.
- Patients appeared comfortable.

Nutrition and hydration

- Bedside care records included charts that showed at a glance the patient's fluid and food intake for each day. These charts had been subject to merging of traditional fluid balance charts and food intake charts at trust level.
- Malnutrition Universal Screening Tool (MUST) was used to assess patient's nutritional risk and internal audits results indicated that the wards were completing this within six hours of admission at 90% compliance.
- Nursing staff provided the patients with choices for lunch and evening meals in advance of the meal being served. Overall the patients we spoke with enjoyed the meals.
- Patients were seen to be offered assistance with meals if it was required and all levels of staff were involved in serving meals.
- Ward quality performance data indicated and we saw that protected mealtimes was being used. Protected mealtimes was designed to allow patients to eat their meals without disruption and enable staff to focus on providing assistance to those patients unable to eat independently.
- Water jugs and cups were provided within patients reach and hot drinks rounds took place regularly throughout the day.

Patient outcomes

Medical care (including older people's care)

- The trust did collect data regarding discharge delays for Fairoak Ward. The trust confirmed this was reported regularly to the Integrated Health and Social Care manager.
- The readmission rates provided by the trust showed the ward had 49 patients that had been readmitted to the ward between November 2014 and the end of May 2015.

Competent staff

- The ward manager told us two members of staff required an appraisal; data supplied by the trust demonstrated an appraisal completion rate for the ward was 80% in May 2015.
- Staff were able to discuss their appraisal outcomes and access to further development such as study days or being a link nurse for an area of interest.
- A student nurse working on the ward had really enjoyed the placement due to the real focus on working as a team. They had found the staff very supportive able to complete learning outcomes and hoped to work on the ward in the future when she qualified.

Multidisciplinary working

- Throughout the inspection we saw evidence of multidisciplinary (MDT) working, with medical, nursing and therapy staff having discussion regarding patient's progression.
- Evidence of regular MDT meetings was present in the patients care records, which were usually led by medical staff.
- Physiotherapists and occupational therapists worked on the ward Monday to Friday to support patient's rehabilitation needs.
- There was a phlebotomy service to the ward five days a week. A phlebotomist visiting the ward to take patient's blood told us that the ward organised the request cards every day in advance.

Seven-day services

The majority of the support services for the Cannock Chase Hospital site operated on a Monday to Friday basis with out of hours arrangements for nights and weekends including; pharmacy available five days per week on-site with weekend support from New Cross Hospital.

- Phlebotomy and pathology samples were collected daily (including at weekends) for processing at New Cross Hospital.
- Portering and security staff were on-site seven days a week.
- Some diagnostic testing (Echo, lung function, ultrasound, x-ray, Magnetic Resonance Imagining (MRI)) was available on-site weekdays during office hours. Others required transfer of the patient to the New Cross site with nurse escorts.
- Endoscopy and insertion of percutaneous endoscopic-gastrostomy (PEG) feeding tube was available on-site during weekday office hours.
- Access to specialist support from microbiology, tissue viability and safeguarding was via on call, 24 hours a day.

Access to information

- A large wipe board was used which contained the patients listed on the ward. This was updated by staff and appeared current. At a glance, key information could be seen; including patients that were at risk of falls, length of hospital stay and those to be reviewed by therapists.
- Patient's care records were kept securely in notes trolleys on the ward area and they were found to be well organised. The care records we looked at were chronological with clearly signed and dated entries.
- Patients were transferred with their care records from New Cross Hospital so the ward team had access to relevant information about them and their care and treatment.
- Staff told us that discharge summaries were completed to provide information regarding medicines to take home and any on-going treatment to the patients GP, relatives or place of care.
- Policies and procedures were available via the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were witnessed to obtain consent from patients prior to any care or intervention taking place.

Medical care (including older people's care)

- When appropriate, consent forms were completed and copies filed in the patient's care records.
- The staff demonstrated having a range of awareness of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards and most were able to discuss their responsibilities.
- Two patients on the ward had been assessed as lacking capacity to make decisions regarding their discharge and care placements. Formal mental capacity assessments were documented in the care records detailing the findings. In one case an Independent Mental Capacity Advocate (IMCA) was involved to represent and support the person in relation to their best interests.

Are medical care services caring?

Good

Patients were treated with kindness, dignity, respect and compassion on Fairoak Ward. Patients and those close to them were involved in decisions about their care particularly relating to discharge planning.

Patients and those close to them received support to cope emotionally with their care and treatment by all members of the nursing, medical and MDT on the ward.

Compassionate care

- We observed that patients received kind, caring and compassionate care on Fairoak Ward.
- Patients told us that they were well looked after and found all the staff to be caring in their duties.
- Patients said the staff were always very understanding.
- There were many instances of caring staff-patient interactions seen, for example the consultant introduced herself to a patient during the round. During this discussion the consultant positioned themselves in order to be face to face with the patient who was sat in a chair. There was use of gentle reassuring touch by the consultant, stroking the patients hand and showing genuine interest in the patients experience and providing time for responses.
- The domestic assistant chatted with all the patients in the bay as they worked and it was evident that patients liked the friendly conversations. They were also sensitive when staff provided personal care and went back to that patients bay once staff had opened the curtains.-
- Friends and family test results show 100% of those patients completing the survey would recommend the Fairoak Ward to their friends and family if they required the services.
- Patients were treated with dignity and use of bed space curtains was made as appropriate. The curtains had reminders on them regarding respecting patient's privacy.

Understanding and involvement of patients and those close to them

- Patients felt that they were involved in decisions about their care and treatment. Their relatives told us that they were kept up to date by the ward team especially regarding discharge planning.
- Evidence was seen in care records of a discharge planning meeting involving family members; this was chaired by the consultant, with members of the patient's family present and of nursing and members of the multidisciplinary team. The patient did not attend due to lack of mental capacity.
- Patients told us that staff always came back to them if they queried something about their on-going care or treatment.

Emotional support

- All of the patients that we spoke with were positive about the care and attention they had received on Fairoak Ward. They felt treated with respect and found support from other patients as well as the staff.
- The trust informed us that the Hospital Anxiety Depression Score (HADS) is used by the doctors and the occupational therapy team to assess patients. Psychiatric assessment was available via referral to the mental health provider, however if patients are identified as requiring counselling following a stroke they could access this via the stroke association.

Medical care (including older people's care)

Are medical care services responsive?

Good

Services on the ward were organised so that they met patient's needs.

There was a multidisciplinary approach to patient's rehabilitation and discharge planning.

Activities were organised regularly in the wards dayroom to encourage patient to patient interaction and mental stimulation.

Patients concerns and complaints were listened to and resolved locally and there was a low number of formal complaints (one received November 2014 to May 2015) however there was no evidence of using this information to improve the quality of care.

Patients accessed care and treatment in a timely way; however staff were concerned about patients being transferred to the ward overnight.

Service planning and delivery to meet the needs of local people

- The ward was a mixture of four bedded bays and side rooms appropriate for the services delivered by the ward. However the layout meant that not all patients could be observed easily. Some areas such as the nursing station were being refurbished in order to improve this.

Access and flow

- The source for the majority of patients admitted to Fairoak Ward was via transfer from New Cross Hospital. Most of the patients were older persons and had complex care and rehabilitation needs. Staff told us that the types of patients that were admitted included patients recovering from a stroke to those living with dementia.
- Staff told us that patients were often transferred from New Cross Hospital to the ward overnight. The ward admissions record book confirmed that in two months (15 April to 17 June 2015) the ward received 10 patient admissions between the hours of 10pm and 11.30pm with half of them coming from New Cross Hospital. This meant that patients were admitted when the nurse staffing levels were at their lowest which could compromise safe care and would also disturb other patients settling down to sleep. Trust policy CP05 January 2015 states that transfers after 8pm must be undertaken only when absolutely necessary to ensure sufficient bed capacity or due to the patients' clinical condition.
- One of the overnight transfer patients was described as arriving in pain and was for palliative care. This was not reported as an incident however they were managed appropriately by the on-call doctor when they arrived on site.
- The ward manager told us that regardless of the time of admission they were expected to accept the patients because of bed capacity problems at New Cross Hospital site.
- At the time of the inspection there were five patients assessed as medically fit for discharge (MFFD) awaiting step down placement. The trust did collect data to monitor discharge delays from when a patient was assessed as medically fit for discharge (MFFD) to actual discharge from Fairoak Ward.
- A discharge assistant supported the wards at Cannock Chase Hospital with patients discharge arrangements. Their responsibilities included arranging transport, monitoring progress with ordering medicines to take home (TTO's) and liaison between social services and patients and their relatives.
- We were told three social workers supported patients and the MDT with assessments and discharge planning. We observed social workers talking to patients and relatives on the ward.
- Patients and their relatives were involved in discharge planning meetings which were documented in care records.

Meeting people's individual needs

- During the inspection we observed a game of 'beetle drive/ bingo' being played by six patients from the ward in the dayroom. with. There was lots of interaction and laughter between patients and the occupational therapists provided assistance to ensure everyone could participate. Patients told us that they liked these sessions and that they often happened on a daily basis in the week.

- Patients living with dementia had 'About me' booklets completed appropriately and held in care records. These contained information regarding the person's preferences which was used to provide individualised care.
- A dementia action plan for Fairoak Ward had been developed to improve the ward staff's understanding of patients living with dementia. This was on display in the ward manager's office and progress was monitored. Areas that were on-going included use of patient centred dementia care boxes to help orientate patients and all staff were to attend dementia friends training.

We spoke with a local ward leader regarding one to one supervision for patients at risk of falls or who were confused.They requested mental health staff for patients with confusion as per the trust policy.For patients who were at risk of falls they would attempt to cover with bank staff.However, in both instances they felt this was difficult to achieve due to unavailability of extra staff. The trust safer staffing data for December 2014 - April 2015 indicated that consistently during day hours they were less trained staff than planned for.Nights were staffed as planned for both trained and healthcare assistants.No additional comments such as mitigation were present for Fairoak ward within the data..

- Patients call buzzers were generally answered promptly during the inspection and patients told us that they were not kept waiting when they needed assistance.

Learning from complaints and concerns

- Staff told us that the ward did not get many complaints because they tried to resolve any issues raised by patients and relatives locally and proactively.
- The ward received a formal complaint in March 2015, (one complaint in seven months November 2014 to May 2015) from a patient's relative concerned about the care that her husband had received. The main issues that were raised in the letter were; wound dressing management and poor communication following a patient's fall. The matron had responded in writing apologising and providing explanations. The issue raised regarding wound care was consistent with our findings and as such may demonstrate that learning from the complaint has not been undertaken.
- The staff we spoke with did not mention the formal complaint and it had not been discussed at a ward meeting suggesting that learning and feedback from the complaint had not been shared with the ward team.

Are medical care services well-led?

Requires improvement 

The leadership, governance and culture did not always support the delivery of high quality person-centred care.

There was not a clear shared vision at ward level. The nursing staff appeared to be isolated managerially, operationally and professionally.

The arrangements for governance did not always operate effectively. This meant that any concerns regarding Fairoak Ward were not raised formally and key safety and governance messages were not shared. Staff did not always raise concerns regarding staffing levels.

The local leadership required time, capacity and support in order to promote good quality care and ensure that services could be continuously improved.

There was a limited approach to obtaining the views of people who use the services.

Vision and strategy for this service

- The ward team overall felt unclear about the vision and strategy for the service. They did not know the direction that the ward was going or the types of patients they may be caring for and this was causing them concern.
- The relatively recent transfer to Royal Wolverhampton NHS Trust (RWT) had left the staff feeling unsettled. One nurse told us that after going through the aftermath of Mid Staffordshire NHS Foundation Trust extensive scrutiny and then receiving support to improve services they had felt they had turned a corner; now however they felt uncertain again.

Governance, risk management and quality measurement

- Fairoak Ward belonged to the Rehabilitation/ Ambulatory group, which aimed to hold monthly clinical governance meetings. The meeting discussed audits, serious incidents, risk register, compliance and action

plan monitoring. In the minutes of the meeting in February 2015, the chair requested that representatives from Fairoak Ward should attend. One of the consultants attended the meeting held in May 2015 but the ward manager had yet to attend. The meetings have had to be cancelled on occasions due to people being unavailable.

- The transfer of some services at Cannock Chase Hospital to the Royal Wolverhampton NHS Trust (RWT) and any risk of adverse impact this may have, was documented on the trust board risk register. It stated that any risks that were transferred with the service were to be managed through the directorate's governance processes and escalated as required. However Fairoak Ward had been poorly represented at these meetings.
- Action plans were drawn up by the trust managers in preparation for the transfer to RWT. Minutes of project meetings showed that detailed planning had been undertaken to ensure the continuity of safe services following transfer. The minutes also showed that consideration for staffing and support were discussed, including welcome packs for staff at Cannock Chase Hospital and ensuring that there were named people on site for queries for the first two weeks in particular.
- The risk register provided by the trust for Fairoak Ward had two entries; the first contained an approved fire risk assessment and the second related to patients being at high risk of falls.
- An incident when a patient fell on the ward resulting in harm was discussed with the team at the next ward meeting. This meant that awareness regarding the incident and any learning was shared with the staff on the ward.
- The ward performance regarding mandatory training, sickness rates, staff vacancy and cardiac arrest resuscitation trolley checks was collated monthly on a performance database. Areas were RAG (red amber green) rated according to predetermined thresholds or targets. The meant that areas for improvement could be seen clearly.

Leadership of service

- The ward manager provided local leadership to the ward team and the staff all spoke highly of them. The ward manager was trying to provide safe services while working clinically to fill staffing gaps. This meant however that they were not able to manage the service effectively. They have been seen working tirelessly; giving out meals, handing over to oncoming teams as well as juggling the staffing rotas during site visits. The staff all agreed that the ward manager was providing support for the team but working so hard that they were concerned about their welfare. While the staff expressed their admiration for the ward manager they felt that they were not receiving any support from higher up in the organisation.
- The ward manager did not attend the sisters meetings which were held at the West Park site. They did not feel it was beneficial to attend as it did not focus on their issues. This meant that the ward manager was isolated from peer support.
- Matron for the ward had scheduled meetings with the ward manager on a fortnightly basis but these did not always happen. The matron was not present at Fairoak Ward during the inspections. Staff told us that initially on transferring to RWT they were visited by trust managers but these visits had not continued. However trust management disagreed with this and maintained that they had a programme of regular visits by senior management staff.
- The ward team seemed isolated with the majority of meetings and training taking place at West Park and New Cross sites. Staff were not provided time to undertake training having to do so in their own time with no recompense.

Culture within the service

- The morale on the ward was described by staff as generally low. However close working relationships and team working especially between the nursing staff was evident. One member of staff described how touched they had been by the extreme kindness they had been shown by the team when they had suffered bereavement.
- The team cared very much about the patients and each other, providing the best care that they could which often meant working extra shifts on their days off and annual leave.

- One of the ward meetings concluded with the ward manager thanking staff for their hard work since the transition and was aware that it had been difficult.

Public engagement

- There was little evidence of public opinion being sought or public engagement within the service at Fairoak Ward. The entrance foyer outside the ward however was full of information for the public. The staff on the ward told us that they felt proud to be continuing to provide services for local people.

Staff engagement

- Monthly ward meetings were held for the staff however minutes showed that approximately eight staff on average attended. The ward manager had asked for ideas from the team regarding how to increase the attendance level.
- The nursing team on the ward appeared very close but did not seem connected to the rest of the trust.

Innovation, improvement and sustainability

- Name stamps for use in care records to easily identify staff including registration numbers had been requested for all ward staff. This was a good practice innovation that had recently been launched at Fairoak Ward however; the care records showed this was not fully embedded.
- The trust had not identified any areas of innovation related to the care of the elderly directorate at Fairoak Ward.

Surgery

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

Information about the service

The Royal Wolverhampton Hospitals NHS Trust at Cannock Chase Hospital offers elective surgical procedures on an inpatient basis as well as day case surgery. Surgical specialities include elective orthopaedic surgery.

There is one surgical ward (Hilton main ward), five operating theatres, one ophthalmology theatre and one post anaesthetic care unit.

Elective orthopaedic care is provided at Hilton main ward at Cannock Chase Hospital. This is a 31 bedded ward providing care to patients undergoing elective orthopaedic surgery.

Until November 2014 Hilton main ward was part of Mid Staffordshire NHS Foundation Trust (MSFT). MSFT has undergone dissolution with transfer of responsibilities for some services (including Hilton main ward) to Royal Wolverhampton NHS Trust (RWT). Prior to the dissolution the services at Cannock Chase Hospital had been the subjected to much external scrutiny for assurance of safety and sustainability and now have undergone a complete change in management. It is through this context that the findings should be viewed. Information prior to November 2014 has not been included in our assessment of the service.

We spoke with 14 patients and 11 members of staff. These included nursing staff, healthcare support workers, and managers. We observed care and treatment and looked at five care records including medication charts and pain management records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Surgery

Summary of findings

Patient safety was monitored on a daily basis. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.

Services were planned and delivered to meet the needs of local people. However, we found that operating lists were published only the day before the operation.

There were systems in place to support vulnerable patients. Concerns were addressed at a local level before the issues resulted in a complaint.

There was clearly visible leadership within the surgical services. However, staff did highlight concerns that there was a tendency for the hospital to adopt new ways of working regardless of perceived value of the new system.

Are surgery services safe?

Good

There were good systems and processes in place to prevent avoidable harm. Patient safety was monitored on a daily basis. Overall standards of cleanliness in theatres and in the ward we visited were good. However, the female changing area in main theatre was cluttered creating a possible challenge for cleaning purposes. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff told us they were fully supported when they do so. Medicines were stored safely and given to patients in a timely manner.

Incidents

- Surgical services reported no never events since the trust took over the management of the service.
- Staff across all areas we visited told us they were encouraged and supported to report incidents. Matrons and ward managers described the processes they used to investigate incidents and how they used investigation findings of incidents to inform their quality assurance processes.
- At Cannock Chase, there was one serious untoward incident reported between December 2014 and May 2015. The incident was a pressure ulcer that was deemed unavoidable after a root cause analysis.

Duty of Candour

- The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and, where mistakes are substantiated, to offer an apology if the patient experienced a defined level of harm or was at risk of harm. The principles aim to improve openness and transparency in the National Health Service (NHS).
- Staff we spoke with understood their responsibilities with regard to the new Duty of Candour legislation. Staff told us incidents involving potential mistakes in patients' care or treatment were investigated and findings were shared with patients, and where appropriate, their relatives. They also described the need for patients involved in incidents to be given an apology.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- Safety thermometer data showed that, since December 2014 for the orthopaedic specialty, there were no falls or urinary tract infections.
- The ward had only one incident of pressure ulcer that was unavoidable.

Cleanliness, infection control and hygiene

- The Hilton main ward and theatres we visited looked clean. Overall standards of cleanliness in theatres and in the ward we visited were good.
- However, the female changing area in main theatre was cluttered creating a possible challenge for cleaning purposes.
- We saw that staff across all three areas wore clean uniforms, with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff.
- Cleaning schedules were displayed on the Hilton main ward and cleaning tasks were clearly identified. Clinical equipment, such as IV pumps, was cleaned by nursing staff.
- Hand hygiene gel was available at the entrance of Hilton main ward and at the bottom of each patient's bed. We observed good hand hygiene practices on Hilton main ward.

Environment and equipment

- Equipment was regularly checked.
- Resuscitation equipment checks in areas we looked at were completed daily. Appropriate resuscitation equipment was available in all the areas we visited.
- Staff said they were able to access equipment that was needed to deliver care safely to patients.
- We visited theatre suites and found they were fit for purpose. Maintenance records showed the trust reviewed the safety and suitability of its theatres and equipment.

Medicines

- Medicines were stored safely. The temperature of medication fridges was monitored.

Records

- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre.
- Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- The paper patient records we looked at were generally legible and well maintained.
- Surgical safety checklists (based on the World Health Organisations WHO checklist) should be used at each stage of the surgical pathway – from when a patient is transferred to theatre until return to the ward. In the patient records we saw, WHO patient safety checklists were always completed.
- In all other areas we visited, patients had clearly documented treatment plans written by doctors and nursing care plans were in place. There were records of care from physiotherapists, dieticians, and pharmacists. The World Health Organisation (WHO) surgical safety checklist was present and completed in all of the patient records we looked at.
- We saw evidence of risk assessments completed for each patient when they were admitted onto a ward. Falls risk assessments were undertaken to alert staff to potential falls risks.
- During one observation undertaken in day theatre, we observed there was no formal "sign in" in the anaesthetic room. There was no introduction by the anaesthetist and no "pause" to discuss issues covered by the surgical safety checklists. There were delays whilst additional anaesthetic help was arranged by the anaesthetist. However, there was no explanation given to the surgeon or the theatre team. During the same observation, a full formal "time out" was taken and this was well embedded. We found there was attention paid to patient safety including the availability of pressure prevention aids. We found privacy and dignity maintained at all times. Hand washing and sharps disposal was undertaken as per established protocols.

Safeguarding

- Nursing staff told us they had safeguarding training and were aware of safeguarding procedures and protocols. They were able to describe situations where they would raise a safeguarding concern.

- There had been no reported safeguarding incidents relating to orthopaedic surgery at the hospital since the hospital was taken over in December 2014.

Mandatory training

- There was an induction programme for all new staff.
- We saw the training figures for nursing staff for mandatory and statutory training for the surgical division. This included fire, infection control, moving and handling and code of confidentiality. All these were over the 90% trust target. Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and could describe what was included in the training. There were monitoring systems in place to ensure staff had completed the necessary training.

Assessing and responding to patient risk

- The ward had a daily written safety briefing that took place during nursing handover to identify patients at risk of harm. These safety briefings included review of staffing, bed capacity issues, risk assessments for venous thromboembolism, pressure ulcers, and nutritional needs, risk of falls and infection control risks.
- Staff used a surgical safety checklist based on the internationally recognised WHO checklist to ensure required pre- and post-operative safety checks were undertaken. Surgical checklists were complete in all patient records we saw.

Nursing staffing

- The day unit staff told us they had the correct number of staff as per their allocation.
- The nursing staff on Hilton main ward and the post anaesthetic care unit (PACU) told us they were working at their allocated numbers. Staff rotate with Hilton main to cover nights and if there are any shortages.
- There were three vacancies at the post anaesthetic care unit (PACU).

Medical staffing

- This trust had slightly more consultants at 44% compared to the England average of 40%. They had 7% middle grade doctors compared to England average of 11%. For the registrar group they were slightly less at 34% compared to England average of 37%. They also had slightly more junior doctors at 14% compared to the England average of 13%.
- There was a daily safety and staffing briefing in theatres.
- Anaesthetists were on call and on site at night and during the day.

Major incident awareness and training

- There was a trust major incident plan that was being worked on. Staff told us there was no site specific major incident plan.
- Emergency plans and evacuation procedures were in place.
- Staff told us about the hospital's business continuity plans and said these had been used to manage demand for services over the winter.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively.

Patients received pain relief suitable to them in a timely manner.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Most staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- The use of national guidelines and the enhanced recovery programme was used, where relevant.
- Regular clinical governance meetings were held to discuss changes to guidance and the impact of changes on services.

Pain relief

- All patients we spoke with reported that their pain was well-controlled and staff provided them with pain relief promptly when requested.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the wards.

- We observed that patients usually had access to drinks which were within their reach.
- The patients told us they were given meal choices and most rated the quality of food as adequate. In the national inpatient survey published in April 2015, the trust scored 5.5/10 for describing the hospital food as good. The trust scored 8.8/10 for having been offered a choice of food and 7.3/10 for being given enough help from staff to eat their meals, if they needed this. The trust scored 'about the same' in all these area as similar trusts nationally.
- We observed meal times and found patients who needed assistance were identified to staff and were being provided with necessary assistance.

Patient outcomes

- Standardised relative risk readmissions for elective surgery at Cannock Chase Hospital compared favourably with national comparators.
- The data for the National Joint Registry was 100% complete. This registry collects information on all hip, knee, ankle, elbow, shoulder replacement operations, and monitors the performance of joint replacement implants.
- There were clear set pathways in place for operations. These pathways ensured patients were discharged after their operations in a timely manner. These pathways avoided unnecessary stay in hospital. The trust audited these pathways and the results showed that patients were discharged according to the set guidelines.

Competent staff

- Nursing staff told us they received annual appraisals and regular supervision.
- The trust had a procedure it was following to achieve revalidation for medical staff.
- The trust had ensured staff were trained on the use of high risk medical devices. It was now undertaking a similar programme for medium risk medical devices. The results of these were submitted to the board on a regular basis.

Multidisciplinary working

- There was evidence of multidisciplinary team working in all areas we visited. Staff on the ward confirmed that the multi-disciplinary approach was part of the culture of the trust.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these.
- Patient records showed patients were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.

Seven-day services

- Staff told us there were consultant available for a seven-day service.
- Physiotherapy was available seven days a week for orthopaedic patients. Reduced physiotherapy was available on weekends for patients who needed it.

Access to information

- Patient records were stored in hard copy.
- Staff told us about the handovers between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On both sites of the hospital (Cannock Chase Hospital and New Cross Hospital) we found patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required.
- Where patients were confused or there was a question about their capacity to consent, mental capacity assessments were undertaken by medical staff to determine whether they could make decisions relating to their care and treatment.
- However, we found a few ward staff at Cannock Chase Hospital were not clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLs). They were unable to summarise the key points of the MCA and the implications of the MCA on their work.

Surgery

Are surgery services caring?

Good

Surgery services at Cannock Chase Hospital were caring. Nursing and ancillary staff were kind and compassionate and took into account the needs of friends and family as well as the patients they were caring for. Systems such as Language Line and dementia awareness tools were in place to help with communication, emotional support and to promote independence. Patients felt well informed and involved in their care. Staff were aware of the need to treat people with dignity and respect and the need to develop and improve care based on patient feedback.

Compassionate care

- We spoke with 14 patients about their care. They were all positive about the care they received.
- We observed a patient having a physiotherapy session. The physiotherapist's manner was very reassuring and kind. The physiotherapist spent time to make sure the patient understood the exercises they would need to carry out once they were discharged home.
- We observed nursing staff behaving in a professional and sensitive manner towards patients and displaying an appropriate level of humour and friendliness.
- We observed one patient in the Day Surgery Unit. The Day surgery Unit staff introduced themselves and asked the patient how they would like to be addressed. The staff helped the patient onto the operating table and paid attention to their privacy and dignity throughout the procedure and afterwards. The staff advised the patient that they would have to stay in hospital overnight and asked if there was anyone who needed to be informed. The patient was given a full explanation of why they had to stay overnight.
- Separate waiting areas were available in the Day Surgery Unit, one for male patients, one for female patients and one for relatives.
- The Friends and Family Test survey for Hilton main ward had good response rates up to November 2014 averaging 39.3% to the national average of 31.7%. Due to a change in the way the survey was delivered to patients, (it was removed from the patient televisions) the response rates had dropped. The Friends and Family test survey cards were now available and all staff promoted the use of these. Friends and family test asks patients on discharge from hospital 'How likely are you to recommend our service to friends and family if they needed similar care or treatment?' Out of the 26 responses for Hilton Main Ward from January to March 2015, 21 patients said 'extremely likely' and 2 patients said 'likely'.

Understanding and involvement of patients and those close to them

- We spoke to a range of staff including a ward manager, reception staff, nurses and health care assistants. All staff expressed their desire to create a good patient and carer experience.
- A recent addition to the orthopaedic ward was the appointment of a hostess. One of the roles of the hostess was to carry out the two hourly comfort checks of all the patients. The ward had regular set visiting times and aimed to have a quiet time in the afternoon for all patients
- Patients were encouraged to dress in day clothes following their surgery
- Staff told us that they tried to attend to things that were important and, made a difference to patients. For example one elderly patient had a preferred breakfast cereal not available on the ward menu. Staff arranged with the kitchen for this cereal to be prepared and available for the patient. Staff also told us that small children often got bored when visiting relatives in hospital and when this happened offered drinks and snacks to them. Staff told us they would always try and respond positively to special requests from patients and relatives.
- Staff in the Day Surgery Unit told us that when people with a learning disability were admitted their relatives or carers were encouraged to stay with them to help reduce anxiety. On occasions it had been known for the relative or carer to go into theatre with them for emotional support.
- One patient told us they were fully informed at all stages of their treatment. This meant they knew what to expect at each stage.

Emotional support

- We observed the chaplain on their weekly ward round. They informed us that they made themselves available to anybody on the ward and also held weekly services in the hospital chapel. Representatives from other faiths also visited the ward such as Hindu, Sikh, and Muslim.

Are surgery services responsive?

Good

Services were planned and delivered to meet the needs of local people. However, we found that operating lists were published only the day before the operation. There were systems in place to support vulnerable patients. Single rooms were made available to people with a learning disability if required.

Concerns were addressed at a local level before the issues resulted in a complaint.

Service planning and delivery to meet the needs of local people

- Recognising the needs of the aging population, the trust had recently agreed a business case to recruit an ortho-geriatrician. This post was going to be advertised shortly. The successful candidate will work across both acute sites.
- The trust told us they were planning to reconfigure some more of their services. This is where a specific service is moved to one location rather than being at both hospitals. Senior staff told us that prior to any discussions being made they would consult with staff and the public.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery or elective inpatient activity.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the orthopaedic wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- Cannock Chase Hospital never cancelled a planned operation unless it was for clinical reasons.
- The hospital did not operated a system where no more patients would be added to the operating list. Sometimes, these lists were published only the day before the operation. It meant that patients were more informed about their procedure than the theatres staff doing that procedure. This resulted in problems with staff trying to locate equipment required for an operation the next day.

Meeting people's individual needs

- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- Patient information leaflets about different conditions and surgical procedures were available in the hospital and on the ward we visited. Leaflets were only available in English.
- Staff told us they had 24 hour access to Language Line interpreters by telephone and could arrange for interpreters to accompany patients at key times during their stay in hospital such as when consenting for treatment or, meetings with hospital doctors and consultants.
- All staff had attended dementia training and whenever a person with a dementia related illness was admitted relatives or carers were asked to complete an 'About Me' document. The 'About Me' document provides information about the person at the time and can help health and social care professionals build a better understanding of the person, it helps to support the person in an unfamiliar place.
- A nurse specialist was available to ward staff to help plan the care of people living with a learning disability.
- Single rooms were made available to people with a learning disability if required.

Learning from complaints and concerns

- Both sites adopted the same approach to handling complaints. Concerns were addressed at a local level

before they became a complaint. Staff told us that this proactive approach helped reduce the number of complaints and gave them opportunities to learn from these complaints.
- Information boards on many of the wards we visited showed information about key concerns raised by patients and relatives and the ward's response. This took the form of "you said we did" posters.

Are surgery services well-led?

Good

The trust had a vision and strategy in place. Senior staff in the surgical service had outlined a service business plan on how they would contribute to this overall vision. Staff in all areas knew and understood the vision and objectives. The focus on patient safety was highlighted as a central. However, staff did highlight concerns that there was a tendency for the hospital to adopt new ways of working regardless of perceived value of the new system.

The hospital undertook monthly patient satisfaction surveys and the results were discussed at monthly governance meetings.

Vision and strategy for this service

- The trust had a vision and strategy in place. Senior staff in the surgical service across both sites were aware of this vision and had outlined a service business plan that incorporated how they would contribute to this overall trust vision.
- Staff spoken with at Cannock Chase Hospital felt there was a tendency for New Cross "ways of working" to be imposed upon them, regardless of perceived value of the new systems. For example, Cannock Chase Hospital has a very clear process of when to take x-ray post operatively. They undertake this in very specific cases. However, the practice of New Cross Hospital of undertaking this x-ray routinely is being imposed at Cannock Chase. This imposition of this practice was a cause of anxiety amongst staff at Cannock Chase Hospital.

Governance, risk management and quality measurement

- In areas we inspected, there were regular monthly governance meetings to discuss patient safety and quality issues.
- Monthly patient satisfaction surveys were undertaken for elective orthopaedic unit. The results of the survey were discussed at team meetings. The overall results highlighted patients were satisfied with the service. Most of the comments on the form highlighted the positive aspects of the service. There were a few negative comments. These were shared with staff so they could be aware of these and improve the patient experience.

· The services had begun to integrate with clinicians from New Cross coming to operate and Cannock Chase and vice versa. However, there were not yet fully integrated. The process was described by staff as a "challenge." There was cross-site working and there were weekly telephone calls to plan nursing staffing requirements with New Cross.

- The service had a central risk register across both hospitals.

Leadership of service

· Staff told us they felt supported by and listened to by their immediate line managers.

· The clinical director for surgery recognised the importance of integration and considered this as a high risk issue for service delivery. There were plans in place to engage clinicians on how this integration could take place. The trust confirmed that meetings had taken place, part of the process was to ensure that the directorate at both sites worked together to find solutions to integrated working.

· Staff we spoke with knew who the chief executive and nursing director were.

Culture within the service

· Staff told us they would feel comfortable in reporting any concerns to their line manager or a senior member of staff. Staff were also aware of the trust's whistle blowing policy and raising concerns policy and where to find them.

· Staff told us there was an open culture that was not about blame. They were encouraged to report incidents as it was seen as by the trust as important learning. There was willingness of staff to support and cover each other to maintain staffing levels.

Public and staff engagement

Surgery

· The hospital issued a weekly brief that highlighted various reminders such as the uniform policy, to ensure all staff receive communication regarding the hospital.

· However, staff felt there was a general lack of information about service transfer. This led to a feeling of isolation and disconnection.

· Theatres and ward-based staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.

- The trust's proactive approach to complaints had resulted in a positive outcome with a reduction in complaints.
- The PACU (recovery) had two volunteers who helped patients by making tea or pouring water for them. They talked with patients and gave them company if so required. Patients valued the time given by these volunteers

Innovation, improvement and sustainability

· The patient care pathways for orthopaedic surgery ensured that patients were discharged in a timely manner.

End of life care

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

Information about the service

End of life care at Cannock Chase Hospital sits with the Specialist Palliative Care Team (SPCT) based at New Cross NHS Hospital as of April 2015. The palliative team received 937 referrals across the trust (Apr 2014–Mar 2015) 30% of the referrals were for non-cancer patients. The hospital did not have specific palliative care beds. Specialist Palliative Care Team (SPCT) provides support and advice for those patients who have complex care needs and/or complex symptom management. Support is also provided to relatives and/or representatives of patients at the end of their lives. Referrals are accepted for any patient with a life threatening condition who has complex physical, psychological, social or spiritual needs.

SPCT is available Monday – Friday from 08.30 – 17.30. Outside of these hours, SPCT advice is available via the on call team at Compton Hospice. End of life care was delivered where required to patients on Fairoak ward by the ward staff.

The mortuary had the capacity for nine patients and there have been eight deaths since the transition to The Royal Wolverhampton NHS Trust in November 2014. The bereavement office was managed by County Hospital University Hospitals of North Midlands NHS Trust.

The Department of Spiritual and Pastoral Care provides a multifaith support service to patients and staff. The department is staffed by a team of whole time and part time chaplains who work alongside volunteer chaplaincy visitors. The service is accessible 24 hours per day.

During the inspection we visited Fairoak ward and met with one patient who had used the service. We spoke with the SPCT and seven staff which included two medical staff, three nurses and two porters. We spoke with the chaplain at New Cross Hospital who supported Cannock Chase Hospital. We visited the mortuary, chapel of rest, Muslim prayer room and non-denominational room. In total we reviewed five care records.

End of life care

Summary of findings

The Specialist Palliative Care Team (SPCT) provided a safe, effective and responsive service for people with life-limiting illnesses. The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

The palliative team were in the process of embedding the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) and staff returned jewellery in a small box. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information leaflet' and the feedback survey was redesigned to have the Swan logo.

The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few end of life patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.

The Specialist Palliative Care Team worked closely with Cannock Chase Hospital to support patient pathways through the hospital.

The staff knew how to make referrals and people were appropriately referred to and assessed by the SPCT in a timely fashion. Seven day working was not in place but staff had access to specialist advice and support 24 hours a day from SPCT.

We reviewed five DNACPR forms, they were completed according to the National Guidelines.

The chaplaincy service supported families' emotional needs when people were at the end of life.

We found leadership of the end of life service to be good. The SPCT promoted a culture of sharing knowledge and developing the skills of others.

Staff were unaware of the major incident plan and actions to take in the event of a major incident.

End of life care

Are end of life care services safe?

Good

The Specialist Palliative Care Team provided consistent, safe care and advice for patients, relatives and staff. The trust was in the process of embedding the Swan Project which incorporated a new personalised care plan for last 24 to 48 hours of life to replace the Liverpool Care Pathway after its national withdrawal in 2014. We were unable to assess the use of the personalised care plan as the ward were not currently caring for anyone during the last days of their life.

There had been no never events or serious incidents requiring investigation reported in relation to end of life care. The hospitals incident reporting system had been in place since 1st April 2015 and no formal training had been implemented for nursing staff on the ward.

Staff were committed to providing person centred care for patients who were receiving end of life care, however specialist palliative care training was not mandatory. There were clear referral processes in place and effective arrangements to assess and coordinate end of life care. All nursing staff spoken with had received safeguarding and syringe driver training.

Staff were unaware of the major incident plan and actions to take in the event of a major incident since the transition to The Royal Wolverhampton NHS Trust in November 2014.

Incidents

- There had been no serious incidents reported attributed to end of life care. No 'Never Events' had occurred within the palliative care service between April 2014- March 2015.
- The palliative care nurse and ward staff were aware of their responsibilities in reporting incidents. The electronic reporting system had been in place since April 2015, no formal training had been implemented for ward nursing staff although staff had managed to use the system. The palliative care team had received training. Incidents were discussed at monthly ward meetings.
- The hospital implemented a system in which any incident throughout the hospital for any palliative or end of life patient could be sent and reviewed by the palliative care team as well as the responsible ward manager. This meant the palliative team were able to review incidents and monitor trends.
- From June 2014-June 2015 there had been 94 incidents reported across the trust in relation to palliative patients. All had been reviewed by managers and action had been taken in order to reduce harm to the patient and details of 'lessons learnt' were documented most of the time.
- The palliative team were able to explain duty of candour and the importance of reporting incidents. The Duty of Candour regulations require a provider to be open and transparent and follow some specific requirements such as when things go wrong with care and treatment, including informing the person and or family.

Cleanliness, infection control and hygiene

- Ward and departmental staff wore clean uniforms and observed the trust's' bare below the elbow' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary we observed adequate supplies of PPE for use by visiting undertakers and porters.
- We found the mortuary to be clean with all wipeable surfaces and clutter free. However, one out of three chairs was visibly soiled in the viewing room.
- Porters were clear on infection control guidelines needed for the mortuary and knew how to access hospital policies.

Environment and equipment

- Syringe drivers were standardized to one type which could help minimise the risk of human or training error, all staff were trained in using these syringe drivers.
- We saw the mortuary did not have larger fridge sizes for bariatric patients, although the staff had plans in place to utilise the mortuary in New Cross Hospital which had a range of fridge sizes.

Medicines

- We reviewed medication administration records across the ward and found these were consistently well completed.
- We saw evidence that staff adhered to guidelines of anticipatory prescribing medication, required to keep

patients that are end of their life comfortable and pain free. Medical staff were aware of how to access anticipatory prescribing guidance on the hospital intranet.
- Records showed that those patients who were referred to the SPCT had their medicines reviewed regularly. This was done in consultation with other medical staff involved with the patient's care. Two of the SPCT nurses was qualified to prescribe medication as needed if patients required this.
- The pharmacy at Cannock Chase could not supply medication for end of life, out of hours; this had to be sourced at New Cross, however when needed this was easy to access.
- We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation.

Records

- We reviewed five medical and nursing care records which included doctor's notes, plans of care and reviews, comfort round charts, food and fluid balance sheets, risk assessments and a range of care plans.
- Care plans for all patients including end of life, lacked detail and did not reflect patient's preferences as they were all a standard template and all read the same. They were not personalised or person centred. Observational charts were consistently completed.
- Medical staffing records were consistently detailed and gave a good holistic overview of the patient during every review. We found that patients nearing the end of their life or palliative were frequently reviewed.
- We reviewed five DNACPR records and found these were consistently well completed. Staff ensured they documented whether the patient had capacity to be involved in the decision making and discussions with families were documented. DNACPR records had been signed and dated by appropriate senior medical staff. Discussions with families were documented in the medical notes as well as the patients preferred place of dying.

Safeguarding

- Staff were knowledgeable about their role and responsibilities to safeguard vulnerable adults from abuse and they understood what processes to follow.
- Safeguarding policies and procedures were in place. Staff understood their safeguarding responsibilities and knew what to do if they had concerns; 76.1% (trust wide) of staff had completed standard safeguarding training and 82.1% of staff from the medical division in which palliative team sits.

Mandatory training

- The hospital had a program of mandatory training for all staff, the palliative team were 100% compliance with their mandatory training.
- End of life staff training was not mandatory for all staff groups across the hospital however we saw considerable measures had been taken to train all staff on the new end of life project 'The Swan'. As from May 2015, an end of life care and bereavement study day was being held monthly which would be available to all hospital staff.

Management of deteriorating patients

- Access to advice and support from the SPCT regarding deteriorating patients was either given on the ward, by telephone or by visit request. Staff told us that the SPCT would respond quickly to requests for advice and support. The palliative team and medical team worked closely with nursing staff and regularly reviewed deteriorating patients.
- Ceilings of care were identified and shared with all the staff involved in their care and treatment. This meant interventions which controlled symptoms would always be offered, but more invasive/futile treatment would not be offered.
- Early Warning Score (EWS) observations were monitored for patients and we saw evidence of staff responding to deteriorating patients.
- Staff recognised and responded appropriately to changes in risk to patients using the service. Risk assessments were seen for the environment, falls and infection control. The assessments were seen to be fully completed and reviewed regularly.

Nursing staffing

- We noted that staff on the ward expressed concerns that they were working at their minimum staffing numbers which has been consistent over the last couple of months. Bank staff were being utilised to cover any shortfalls the ward manger informed us that she was working six days a week to cover. Staff shared concerns that agency nurses were not permitted despite when bank staff were unavailable. Staff did not appear to be

rushed but just continuously busy. When attempting to speak with staff they had to attend to patients and call bells, they were unable to cover for each other to be able to have five minutes to speak away from their allocated bay. We observed that staff prioritised call bells and attended to patients in a timely manner.

- Staff told us their shortfalls affected their ability to be able to provide complex care to patients at the end of their life. We were told incidents had occurred as a result of low staffing levels.
- The palliative care team consisted of one whole time equivalent (WTE) lead palliative care nurse, one WTE advanced specialist nurse, two WTE clinical nurse specialists, 0.69 WTE rapid home to die facilitator, one WTE band seven specialist palliative occupational therapist, two WTE band six palliative occupational therapists and one WTE occupational therapy assistant. The mortuary was manned by the porters.
- The palliative team told us they were currently well staffed, however, to ensure the sustainability of the continual development of the service and the addition of community hospital services they would require additional staff at the community sites and and were putting forward a business case to increase staffing provision.

Medical staffing

- The palliative care team consisted of one whole time equivalent (WTE) specialist palliative consultant with links in the community and one WTE specialist palliative registrar. They did not use any locum staff but were looking at expanding their team. We saw the registrar had regular support and feedback from the consultant on a weekly basis. The registrar had told us it was the best out of three other end of life care placements due to the level of support and encouragement to develop skills, expertise and advance learning.
- The palliative care consultants worked across the acute hospital, the community hospital, Compton hospice and outpatient's department allowing for improved continuity and management of patients who were using more than one of the services.

Major incident awareness and training

- Documents supplied by the trust demonstrated that 96% of staff had undertaken fire safety training.
- The chaplaincy services were on call for any major incidents in the local area.
- Staff were unaware of the specific major incident plan and actions to take in the event of a major incident since the transition to The Royal Wolverhampton NHS Trust in November 2014.

Are end of life care services effective?

Good

Patients identified as having end of life care requirements had their needs assessed, reviewed and their symptoms were managed effectively. Staff recognised that end of life care related to a range of conditions and had training and resources to respond appropriately to patients' individual needs. Multidisciplinary working was in place to support patients to have all symptoms managed effectively.

The SPCT were available five days a week with advice and support available after 5pm from the local hospice.

The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

We saw no evidence that pain assessments were being completed or evaluation being recorded post analgesia administration.

Evidence-based care and treatment

- The palliative team worked across both New Cross Hospital and Cannock chase hospital so we found that evidenced based care was the same across both sites.
- Following an independent review the Liverpool Care Pathway was discontinued across England by July 2014. The pathway was associated with poor experiences of care because of a lack of tailored, personalised care. The hospital were aware of this and had removed all documentation in relation to the Liverpool Care pathway.
- The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted the award winning practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of

the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) and staff returned jewellery in a small box. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information leaflet' and the feedback survey was redesigned to have the Swan logo.

- The rationale for the Swan logo was to trigger a compassionate response, kind communication and respectful care from any staff member. The logo on canvas bags or outside the doors alerted staff to the presence of dying/deceased patients and identifies the relatives throughout the hospital if they are seen carrying the canvas bag and the logo on the door/ curtain was aimed at triggering a calm and respectful environment on the wards.
- All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient. The ward had implemented the personalised care plan but we were unable to review recently bereaved records as they were sent to the University North Midlands Hospital bereavement office in order for processing the death certificate.
- The SPCT provided specialist guidance to staff on the ward about end of life care.
- The National Care of the Dying Audit (Hospital) (NCDAH) (2013-2014) results were not available as these were collected as a part of University North Midlands Trust and could not be separated for analysis.
- The palliative care team however had been involved with collecting data for the NCDAH New Cross Hospital and were implementing the same improvements since the takeover of Cannock Chase Hospital.
- The Palliative & End-of-Life Care Strategy 2015 addresses NCDAH areas for improvement and sets the direction for the service. We saw measures had been taken to correct these performance indicators and the hospital had registered for this year's audit to see how well they were meeting the targets. We saw leaflets had been developed as a part of the 'Swan Project' to improve the KPI 'access to information relating to death and dying'. We saw considerable steps had been taken to train all staff trust wide in the Swan Project and specific training for ward staff to improve the KPI 'care of the dying: continuing education, training and audit' and promoting patient privacy, dignity and respect . We noted the board now had a representative and had supported the team in implementing the Swan Project trust wide. The team were currently implementing a more formal feedback processes regarding bereaved relatives/friends views of care and sending out more detailed surveys and comment cards.
- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to recognise, communicate, involve, support, plan and do, the SPCT had developed a personalised care plan for each patient in the last days of life with guidance for staff of how to best meet the five priorities of care. The implementation of the Swan provided the means to address the recommendations of the National Care of the Dying Audit and fulfil the requirements set out by the National Leadership Alliance for the care of Dying people.
- As recommended from the five priorities of care, we found that care notes included food and drink charts, symptom control was regularly reassessed by medical staff and psychological well-being was assessed often. However it was not always clear pain and spiritual support had been assessed.
- Staff showed awareness and knowledge of NICE guidance. Staff developed guidelines where no national guidance existed, for example with the use of the medicine naloxone when given to palliative care patients to combat the side effects of too much pain relief such as respiratory depression.
- Policies were available for porters to inform their practice when transporting patients.
- The palliative care consultants engaged in research trials such as:- the hydration in the last few days of life feasibility study and a multicentre randomised controlled trial to assess the impact of regular early specialist palliative care treatment on quality of life in malignant mesothelioma.
- The palliative team were currently piloting the 'Gold Standards Framework (GSF) in Acute Hospitals' at New Cross Hospital on two wards aiming to improve

identification of patients in the last 12 months of life and co-ordination of care across services. This focused targets of best practice for the staff to be able to audit care and develop a benchmark against these standards. The results from the pilot would inform the decision as to whether roll out across other hospital wards would be carried out.

Pain Relief

• Pain management was not always assessed and recorded. Symptom control did not include pain scores or tools. The patient records we reviewed displayed that they received appropriate pain relief. There was no evidence of pain assessments being completed or evaluated post analgesia administration. However, we were told the 'Abbey' pain tool was used for patients living with dementia or a learning disability, this was used in conjunction with clinical observations including facial, vocal, behavioural and physical signs.

• Staff told us that they had access to an adequate supply of syringe drivers and appropriately trained staff to set up this equipment.

• Medication for pain relief was reviewed by the SPCT at each of their visits to review patients. Staff told us that should they find pain control complex or ineffective, they would have no hesitation in contacting the SPCT for advice and support. They said the SPCT were 'excellent' in their support and advice regarding pain management.

• The patient records we reviewed displayed that they received appropriate pain relief. There was no evidence of pain assessments being completed or evaluated post analgesia administration.

• We spoke with one patient who told us the SPCT supported them emotionally and with psychological pain, offered analgesia and monitored effectiveness when they visited.

• Anticipatory medicines were being prescribed.

• The pharmacy at Cannock Chase could not supply medication for end of life, out of hours; this had to be sourced at New Cross. However we saw medicines were planned for end of life patients in anticipation of symptoms. This was undertaken to ensure patient comfort

Facilities

• Ward staff told us that any patients identified as being end of life would be preferably placed in a side room, for privacy and dignity. Family members were able to stay overnight and also had open visiting access throughout the day.

- A multi-faith prayer room was available for patients, relatives and staff. We saw that this lacked capacity to enable both Muslim men and women to pray separately.
- The bereavement office was still under the management of the previous affiliated trust the University North Midlands Hospital. This meant families would have to collect death certificates and belongings from the office at that trust site. Staff told us this may be confusing for families but did not have any issues impact of the families or staff. They told us it was their normal way of working before the hospital joined the Royal Wolverhampton Trust.
- The ward had a room in which staff were able to use if they needed to have private discussions with families such as, breaking bad news.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST, appropriate nutrition and hydration monitoring tools had been used by staff. These included monitoring charts for food and drink taken.
- The SPCT told us that staff on the ward took time to support those patients who could not access drinks or food independently.
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.

Patient outcomes

- At both New Cross Hospital and Cannock Chase we found the hospitals did not audit the percentage of preferred place of death so they could not be certain of the exact amount of patients that die in their preferred place. Staff told us they recorded it in the Somerset software but did not review it. We saw this was also well recorded in the medical notes from the five care records that we reviewed. It was evident from the care records that if the person wanted to die at home it was a priority

for staff and was continually reviewed and discussed with families. Staff told us they had very little deaths at the hospital because they ensured the person died at their preferred place of death which was often at home.

- Personalised care planning enables patients to plan their future care within an advance care plan. We did not see evidence of the Swan personalised care plan as there were no patients in the last few days of their life on the ward during inspection. We were unable to obtain records from the bereavement office as all records continued to be sent to the previous affiliated trust, the University North Midlands Hospital. Staff told us they had used the Swan care plan on all patients that had been there recently and were at the end of their life.
- Medical staff told us that there was effective multidisciplinary team working to ensure the most suitable outcomes for patients.

Competent staff

- Members of the palliative care team were qualified to meet people's needs. Documents supplied by the trust indicated that every member of the team was qualified to degree level and some completed master's modules. Two had completed the non-medical independent prescriber's course, one had a certificate in counselling, one had completed level two psychology training and all had completed advanced communication skills training in 2010.
- We saw evidence from the specialist palliative care work programme June 2015-June 2016 of on-going continual professional development and identified training needs for the team.
- The SPCT had been providing end of life care at the hospital since April 2015 since the SPCT developed a programme of training which was delivered to all clinical teams and all wards at the hospital.
- The palliative care team provided some training for medical staff in addition to the medical university training course. Medical staff had bi-annual palliative care teaching as a part of the foundation trainee course, core medical training programs and DNACPR training for GPs.
- Staff had developed E-learning packs for use by GPs which was designed for sharing clinical learning from the acute into the community.
- The nursing development programme; new starter induction training included: - end of life care teaching in practice, breaking bad news e-learning and the lead palliative nurse told us a bespoke teaching programme could be arranged according to development needs identified by line managers. Overseas nurses received an introduction to end of life care.
- The palliative care team had implemented the use of 'Swan Champions' to ensure there was a palliative link in most areas whose responsibility would be able to disseminate information and learning to staff in their area. There were two band six senior nurses that had undergone the Swan training and two band five Swan champions on the ward.
- The SPCT in conjunction with the chaplaincy service had involvement in the roll out and education of the Swan Project across the trust.
- Policies and training were in place for portering staff to ensure staff and visitor safety in the mortuary. The porters we spoke with told us that they had received training to support the movement of deceased patients to the mortuary. The 'on the job training' included the use of the mortuary out of hours to ensure that mortuary procedures were maintained. They were able to describe the process and were able to demonstrate how they treated deceased patients with dignity and respect.

Multidisciplinary working and coordinated care pathways

- Close working relationships were maintained at the hospital between the SPCT who provided their services across hospital sites this ensured that patients' care and treatment was planned and co-ordinated.
- Both New Cross Hospital and Cannock Chase Hospital had a "Rapid Home to Die Care Bundle" supported by the rapid end of life discharge facilitator for discharge to a preferred place of care within hours or a few days. Staff we spoke with were aware of this.
- We found that a member of the SPCT attended the ward on a weekly basis.

Seven-day services

- The SPCT provided a Monday – Friday service from 08.30 – 17.30 hours across both hospital sites. Outside of these hours, palliative care advice was provided via the on call team at Compton Hospice.
- The chaplaincy provided a service five days a week. An emergency call out service was available out of core working hours.

End of life care

Access to information.

- Staff had access to end of life information and guidance on the intranet. Staff found this resource valuable and easy to access.
- There were two Swan champions available on the ward. The exception to this was on the Hilton Maine that did not have many patients with end of life care needs. However, the ward sister from Hilton Maine was able to explain about end of life pathway and the Swan when asked.
- The Bereavement office and the team were managed by County Hospital part of University Hospitals of North Midlands NHS Trust and when a patient had deceased the notes were transferred to County Hospital.

- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- During our inspection, we reviewed five do not attempt cardio-pulmonary resuscitation (DNACPR) forms. In one of the five DNACPR the implementing doctor had reason to believe the patient lacked capacity, but had not undertaken a formal assessment. We noted that four out of the five DNACPR forms, reasons for DNACPR was completed, communication with patient documented or reason for not discussing it with the patient was documented. Discussion with next of kin were documented and all forms were signed by the Consultant.
- We spoke with the ward manager who was aware Deprivation of Liberty Safeguards and gave an example of a patient who had been transferred from another hospital with issues relating to Deprivation of Liberty Safeguards.

Are end of life care services caring?

Good

Compassionate and person centred end of life care was provided to patients on the ward by medical and nursing staff and by the Specialist Palliative Care Team (SPCT). Patients told us there was nothing more they thought that staff could do to support them and that staff always went above and beyond their expectations

The Swan Project allowed for a person centred approach and reflected the caring culture for end of life care seen throughout the hospital.

Staff across the hospital provided emotional support to patients and their relatives. Volunteers from different faiths were used to support patient's religious needs.

Compassionate care

- During our inspection we observed that the ward sister was compassionate and caring. She ensured that privacy was maintained and treated patients with dignity and respect.
- We were told by the ward manager that an end of life patient was unable to eat or drink but staff gave the patient a mouth swab dipped, the patient's favorite drink which was beer.
- Porters were able to tell us how they would honour the cultural and spiritual wishes of the deceased.
- The lead palliative care nurse told us that staff on the ward had facilitated a pet to visit the ward for an end of life patient.
- Within the Swan Project the palliative team had introduced a symbol that was used across all clinical areas to identify patients who were receiving end of life care. Privacy was maintained by keeping the curtains drawn if requested by the patient and or family and the Swan logo would be placed on the curtains to indicate an end of life patient was being nursed in the bay.
- As part of the end of life care plan relatives were offered keeps sakes' of their relatives which included a lock of hair, handprints and photographs. Staff were able to demonstrate the end of life care box that held all the 'care after death' items. Staff confirmed they offered families 'keep sakes".
- Staff across both sites told us they gave palliative patients their favourite drink in order to keep their mouth moist as opposed to mouth wash.

Understanding and involvement of patients and those close to them

- Staff were committed to working in partnership with patients.We spoke with one patient who was, positive about the care they had received. The patient told us there was good communication, total empathy and they had received excellent medical care.

End of life care

- During the inspection we were able to observe a palliative patient being reviewed by the lead palliative care nurse. The lead palliative care nurse performed the review in a sensitive, caring and professional manner engaging well with both the patient and ward staff.
- A patient told us that because of the sensitive but frank discussions about their care with staff they were able to openly discuss their concerns without feeling rushed.

Emotional support

- The chaplaincy provided pastoral care. They also offered spiritual care, for patients who required it. The chaplaincy services were available to access different faiths.
- Patients' emotional and social needs were included in their care and treatment plan. The Swan care plan included a spiritual assessment to inform staff of the patient's choices and needs.
- The palliative team told us for cancer patients which consisted of 70% of the palliative patients referred to the palliative team, a clinical psychologist was available.
- We also saw that pre and post bereavement counselling was available across the trust for patients known to Compton Hospice.

Are end of life care services responsive?

Good

Patients' individual needs were responded to by ward staff and SPCT. Most patients were seen by SPCT within 24 hours. The trust had a 'Rapid Home to Die Care Bundle' with support from the rapid end of life discharge facilitator for discharge to a preferred place of death. The SPCT was responsive to requests to support patients with complex end of life symptoms and care needs.

The mortuary team were responsive at managing capacity within their service and worked well with New Cross Hospital to manage capacity of mortuary refrigerator spaces.

Multi- cultural faith needs were met. There was a chapel, a non-denominational room and a Muslim prayer room which was newly decorated. However there was a lack of signage to indicate where these areas were located and no signs identifying the Muslim prayer room.

The bereavement office and the team were managed by the County Hospital part of University Hospitals of North Midlands NHS Trust.

Service planning and delivery to meet the needs of local people

- There was no dedicated specialist palliative care ward across the trust. People reaching the end of their life were nursed on the main ward in the hospital. As part of the end of life plan those patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. This allowed for privacy. The ward staff told us they had the capacity to move a dying patient into a side room if they were not already in one.
- The medical and nursing staff on the ward stated that the SPCT were helpful and accessible.
- The palliative team were able to provide us with their demographic figures, most all of their patients were white British and 70% were cancer related deaths. The team were aware of the need to monitor these figures to ensure they were able to provide the correct care that met the needs of the local people.
- The SPCT were acting and responding to new referrals in a timely fashion with 95% of new referrals being seen within 24hours across both hospital sites.
- The palliative team contributed to a Clinical Commissioning Group (CCG) end of life strategy care group which reviewed their compliance with NICE and looked at areas where they needed to better plan and deliver the service to better meet people's needs.

Meeting people's individual needs

- Across both sites, staff told us they displayed the Swan logo which was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible.
- The Swan canvas bag was also available trust wide. This highlighted to all staff that the relatives have suffered a recent loss and may require extra support. It was more dignified to receive the deceased patient's belongings in this way rather than in a plastic bag. Staff thought this was a great idea in identifying relatives throughout the hospital.

End of life care

- Comfort bags had been introduced to support relatives who wished to stay overnight but did not have any items to freshen themselves up. The comfort bags contained soap, tissues, toothbrush and toothpaste for patients and their relatives.
- We visited the chapel, non-denominational room and a Muslim prayer room and found that multi-cultural faiths were catered for, and had been newly decorated. The Chapel, non-denominational room and a Muslim prayer room was open 24 hours a day for prayers.
- When we visited the Muslim prayer room, there were prayer matts and multi faith books available and there was an ablution area. The room was small and would not accommodate a separate area for male and females to pray. There was a lack of signage informing people where to find this room.
- No religious symbols were in place throughout wards, quiet rooms or in the mortuary on either hospital site. Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they care for. They were able to explain procedures for caring for patients with different religions and how they adapted the care accordingly.
- Information was not available for people with different ethnicity. The limited written information and posters available were only written in English.
- We visited the mortuary which appeared organised and it was evident that the dignity of the deceased was an on-going important consideration. The viewing room was available for relatives to spend time with their loved ones.
- We noted evidence of palliative staff working with the informatics department to develop a palliative intranet which would contain up to date information for staff as well as guidelines and useable documents trust wide. Although we did not see evidence of the target completion date in the specialist palliative care work programme June 2015-June 2016.
- We saw leaflets and booklets were available trust wide to relatives with practical information following a death.

Access and flow

- The SPCT operated Monday to Friday 8.30 to 17.30 with out of hours advice provided by Compton Hospice.
- The palliative team had a telephone referral, face-to-face and a bleep referral system in place across both hospital sites. We noted the team were easily accessible and were very supportive of ward staff. Staff told us that if they needed support immediately the palliative team were able to provide a very quick and responsive service. A member of the SPCT was visible on the ward when we visited. Nursing and medical staff knew how to contact them. Referrals were made by telephone and ward staff told us that there were no delays in patients being seen.
- The palliative care team had developed a care pathway for those patients who were in their last days of life and preferred to be cared for at home. The 'Rapid Home to Die Care Bundle' facilitated a rapid discharge. Staff told us they had used this bundle several times across both sites and on several occasions were able to discharge patients with a complex package of care within 24 hours.
- The palliative team consisted of a rapid access discharge nurse whose role it was to develop and implement the rapid access discharge. The bundle had a tear off sheet for the community staff to send feedback about the discharge to the palliative team. It reviewed the effectiveness of the discharge such as transport, equipment and communication. The rapid discharge nurse's responsibility was to support and teach staff how to execute a rapid discharge as opposed to carrying out the discharges. Ward staff told us the bundle had been successful however there was no audit to be able to see the results at the time of the inspection.
- The portering service managed the mortuary and they were supported by New Cross Hospital mortuary staff if they needed advice. We visited the mortuary viewing suite, where families could go and spend time with their relatives. This would be organised by the portering service.
- The mortuary had a capacity of nine refrigerators; one was in use when we visited. The service had good links with other hospitals. The mortuary at Cannock Chase Hospital had been used as an additional storage space for New Cross Hospital when required. We were told by the porters that they had good links with funeral directors in the community and never had any issues with collection.
- The Bereavement office and the team were managed by County Hospital part of University Hospitals of North Midlands NHS Trust. We spoke with the ward who stated that they telephoned County Hospital to inform them

when someone passed away. The nursing and medical team stated that there had not been any issues in contacting them or problems with completion of paperwork.

Learning from complaints and concerns

- The ward manager and the palliative lead nurse confirmed that there had been no complaints reported attributed to end of life care from June 2014-June 2015.

Are end of life care services well-led?

Good

The SPCT had a clear vision for their service. The leadership, governance and culture promoted the delivery of high quality person centred care. The SPCT displayed good engagement and attendance at national/ international conferences and the West Midlands expert advisory group for palliative care.

The SPCT felt the trust were engaged with topics around end of life care.

We noted SPCT had made efforts to engage the trust wide staff and were determined to improve care for patients at the end of the lives and better support families. We saw SPCT were very passionate about their job and told us they enjoyed what they did.

We reviewed the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Hospital. We saw they had worked on a number of areas to ensure improvement and efforts were made to ensure the sustainability of the service.

Vision and strategy for this service

- The SPCT had developed a palliative and end of life care strategy (updated June 2015). This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust. All staff we spoke with were clear about the importance of end of life care and the need for it to be recognised, planned for and delivered to meet the patient's needs.
- Staff told us there was no clear vision or trust consultation for the future of the ward.
- We saw a strong level of commitment from all staff to all the palliative team's projects and saw the passion from the palliative care team was distributed throughout the hospital which we found was as a result of a clear vision and strategy to engage all staff.
- We saw the palliative team had a clear vision for their service such as:-additional cover for the hospital, seven day face to face specialist palliative care provision, change in lead nurse professional responsibility to include acute and community setting, full implementation of Gold Standards Framework dependent on outcome of pilot, continue to embed the Swan Project and introduction of new Palliative/EOLC education packages to support generalist practice.

Governance, risk management and quality measurement

- The palliative care team based at New Cross NHS Hospital had only taken over the service for end of life care at Cannock Chase Hospital as of April 2015. We saw considerable efforts had been made to engage with staff on the ward and implement and embed the New Cross Hospital guidelines and projects. We saw several good quality measurement systems at New Cross Hospital however these were yet to be embedded at Cannock Chase Hospital. The palliative team developed an annual report in which they reviewed all aspects of their work from research to national audits to improvement plans. We were told this would now include work at Cannock Chase Hospital we saw evidence of this in the palliative and end of life care strategy (updated June 2015).
- We saw the trust had submitted data for the National Care of the Dying Audit (Hospital) (NCDAH) audit (May 2015).

Leadership of service

- The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice. The trust had a board representative who staff told us was very engaging and pushed for palliative care to be on the agenda.

End of life care

- All staff we spoke with from the palliative team thought there was excellent leadership for the service and felt well supported. Staff told us how they ensured they emotionally supported one another through difficult and upsetting situations.
- The medical staff for the palliative care team told us they felt well supported by the consultant and had regular feedback and appraisals.
- Data submitted by the trust showed that the palliative team displayed very good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

Culture within the service

- There was evidence of good positive culture and support seen at ward level. Staff on the ward spoke passionately about the end of life care provided. We saw SPCT were very passionate about their job and told us they enjoyed what they did.
- The palliative care team promoted a culture of sharing knowledge and developing the skills of others.
- On the ward we visited we saw that the SPCT worked well with nursing and medical staff and there was obvious respect between nursing and medical staff.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.

Public and staff engagement

- The palliative team told us they had a public representative that would support them in ratifying their ideas and had reviewed documents and policies from a patient and families perspective.
- Patients with cancer were invited to sit on a user group panel 'Wolverhampton Patient Advisory Cancer Team' to be able provide input in changes to the service. We saw the minutes for the February 2015 meeting where ten staff attended and three patient representatives.
- We saw the team had arranged leaflets, books, DVD's and flyers for the 'Dying matters awareness' day they had organised with the local hospice in order to engage with the public and raise awareness to the importance of end of life plans and bereavement.

Innovation, improvement and sustainability

- Within the strategy document the hospital highlighted areas for improvement, ranging from environmental challenges, hospital-wide awareness and engagement, resource capacity of specialist palliative care services, clearly defined integrated pathways to formal recording of palliative patients' wishes.
- We saw they regarded their strengths to be: - organisational leadership and commitment, a passionate and committed specialist palliative care team, person-centred care philosophy and partnership working and research leadership.
- Staff told us one improvement made by the service had been the appointment of a fixed term, rapid discharge pathway facilitator to develop a rapid home to die care bundle, and associated web resources and education programme.
- The trust had made improvements by developing a unified Do Not Attempt Cardiopulmonary resuscitation form that travelled with the patient across services. This was supported with a newly developed e-learning package.
- The strategy recognised the need for additional cover required specifically for the hospital in order to ensure its sustainability. A business case was being put forward to increase nursing and medical staffing provision of the palliative care team.

Outpatients and diagnostic imaging

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

Information about the service

The Royal Wolverhampton NHS Trust took over the running of Cannock Chase Hospital in November 2014.

The outpatient department at Cannock Chase hospital held a range of clinics including orthopaedics, paediatrics and gastroenterology. We spoke with ten staff including nurses, health care assistants, consultants and reception staff. We spoke with ten patients to gain their views of the services they had received.

The diagnostic and imaging services at Cannock included three x-ray rooms and one ultrasound room. The department is supported by a medical physics department based on the New Cross site. The Radiation Protection Adviser (RPA) sits within the medical physics team. The superintendent was also the Radiation Protection Supervisor (RPS). Although there was a minor injury department on-site at Cannock, there was not the facility to access the radiology department for minor injury radiography. Patients would have to be sent to New Cross Hospital for x-rays.

We spoke with five staff including the superintendent radiographer, a radiographer, administrative staff, an imaging department assistant and an ultrasonographer. We spoke with five patients.

We reviewed 21 sets of records. We also held public listening events. Before and during our inspection, we reviewed the trust performance information in relation to outpatient and radiology services. The local leadership worked across both sites.

Summary of findings

Overall the services within outpatients and diagnostic imaging services required improvement.

Staff were not given post incident feedback, shared learning and changes in practice resulting from incidents.

Completion of children's safeguarding training required improvement in radiography, particularly children's safeguarding. No qualified nursing staff and 17% of unqualified nursing staff had received their appraisal in outpatients. Nursing staff within outpatients demonstrated limited knowledge of the Mental Capacity Act and Deprivation of Liberties.

Radiation risk assessments were generic in nature and not fit for purpose. Standardisation of referral forms in radiography was required to avoid confusion with using two different forms. There were regular delays in paediatric reporting.

There was a lack of a clear vision and strategic planning in both outpatients and radiography. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Outpatients and diagnostic imaging

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to patient individual needs.

Are outpatient and diagnostic imaging services safe?

Requires improvement

The safety domain required improvement.

Staff were not given post incident feedback, shared learning and changes in practice resulting from incidents.

The disabled cubicle in radiography required improvement to ensure the call bell and curtain was fit for purpose.

77% of staff had received children's safeguarding training within outpatients. In radiography not enough staff had received level II children's safeguarding training.

The procedure to check whether women were pregnant prior to receiving radiography tests required improvement to be in line with professional body guidance.

We saw safe practice in relation to infection control, medicines management and records management in both outpatients and radiography.

Incidents

Outpatients

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system.
- A total of 606 incidents had been reported between March 2014 and February 2015. Of these, 569 resulted in no harm, 28 low harm and nine moderate harm. 156 of these incidents were reported as clinical assessment. 103 were reported as documentation and 78 as treatment or procedure.
- Seven serious incidents requiring investigation were reported. These included three relating to slips and trips, one confidential information leak, one grade 3 pressure ulcer and one suboptimal care of the deteriorating patient. This data covers both New Cross and Cannock Chase sites.
- The management told us (and we saw from minutes) that incidents were discussed at governance meetings. Staff told us they were not fed back lessons learned from themes of incidents.

Outpatients and diagnostic imaging

- There had been no 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the outpatients department during the preceding 12 months.

Diagnostic and Imaging services

- Minutes for the Radiation Committee Sept 2014 and the Clinical Governance Subgroup (Radiation) February 2015 meetings indicated that there was no trust executive present at these meetings. It is best practice for a trust executive to be present or for the chief executive officer (CEO) to delegate responsibility to chair the committee. Radiation incidents were recorded at these meetings and agreed follow up actions minuted and progress against the actions monitored at subsequent meetings.
- The managers told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke with confirmed this.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the hospital incident reporting system. Senior staff we spoke with told us that incidents were discussed at departmental governance meetings. Minutes were made available to confirm this. However, there were not clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents with departmental staff. The Clinical Governance lead said the information was on the electronic incident reporting system and the expectation was for staff to check the outcomes themselves.
- Ionising Radiation (Medical Exposure) Regulations IR(ME)R incidents were reported to the medical physics team.

Cleanliness, infection control and hygiene

Outpatients

- Patients we spoke with felt that the areas were always clean. We observed that the waiting rooms and outpatient's clinic rooms were clean.
- We observed that all staff complied with the trust policy of being bare below the elbow.
- Hand gel was available in all clinical areas. There was clear signage for the location of the hand gel. We saw staff requesting patients use the hand gel.
- Mandatory training records showed that 82% of staff had received infection prevention and control level 1 training and 66% level 2 training. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Records provided by the trust demonstrated that 100% of staff had received training in hand hygiene. The hand hygiene audits completed monthly March – May 2015 showed 100% compliance.
- We observed that clean instruments in a sealed box were returned from the clinical sterile supplies department (CSSD) to the sluice. The sister confirmed that the supplies were not opened within the sluice. It would be more appropriate for the supplies to be returned to the clinical storage room.

Diagnostics and Imaging Services

- The department overall appeared clean. Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards.
- Cleaning schedules were completed and up-to-date.
- Personal protective equipment (PPE) equipment including lead coats were checked and were clean and of good condition.
- The Clinical Governance lead reported that she completed the hand hygiene audit on line. When asked what the department's performance was with regards to hand hygiene, she said that she did know what the results were and that the department did not receive any results. Consequently the department staff were not informed of how well they were performing with hand hygiene. Records provided by the trust showed that the hand hygiene assessment completed in January 2015 was 100% compliant.
- Records demonstrated that 100% of the radiology staff had received training in infection control.

Environment and equipment

Outpatients

- We observed that the surroundings were quite cramped within outpatients with little storage space. There was no staffroom.
- There was poor privacy at the outpatient reception area; everyone in the nearby vicinity could overhear

confidential conversations. All areas of outpatients that we visited were tidy, including corridors. The atmosphere was generally calm, even where the clinics were very busy.
- Vending machines were available for food and drink. However, patients complained about the price increases.
- A water fountain was situated down a corridor but was not well signposted for patients.
- There were no facilities for staff to make patients drinks or store food. This meant that patients would have to bring their own food or purchase it from the vending machines.

Diagnostic and Imaging services

- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- In the disabled cubicle the patient alarm button was positioned half way up the wall opposite the patient bench; potentially out of reach for wheel chair users. Also the curtain to the cubicle was made of a heavy material making it difficult to open and close. The superintendent radiographer told us that she reluctantly puts patients in the cubicle. She said that she had reported the curtain several times (but not the alarm button) with no response. This presented a risk to the patients and warranted being entered onto the risk register. However, the superintendent was not aware of the process of reporting risks.
- The Trust presentation highlighted that obesity was a problem within the local population. It was noted that there was no provision of bariatric seating in the waiting areas.
- The medical physics staff stated that they were not involved in the process of equipment procurement (at both sites) which did not allow their advice regarding dose optimisation to influence any purchasing decision.

Medicines

Outpatients

- Medicines were stored in locked cupboards. Medicines that we checked were all in date.
- Lockable medicine fridges were in place. Records showed that daily temperature checks had been recorded.
- Prescription pads were securely stored in locked drawers.

Diagnostic and imaging services

- There were no medicines stored in radiology.

Records

Outpatients

- Some clinics used written patient records and some electronic records. Clinicians reported that they had to access different hospital electronic systems in order to obtain all the notes for a patient. For example they may have to access notes from mid Staffordshire, Stoke and New Cross depending on where the patient had previously been treated. In addition they may have to access different departmental systems. All the records were available electronically but this did slow down the clinics.
- If patient's records were not available (which we were told was rare) a system was in place that the original referral letter from the GP had been scanned in prior to the first appointment, enabling the clerk to bring this up and print out. For follow-up appointments, results and dictated letters could all be pulled up on the electronic systems.
- We reviewed six sets of patient records; all records were complete, with up-to-date typed letters, completed consent forms, clear treatment plans and demonstrated patient engagement.

Diagnostic and imaging services

- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- The trust had a central electronic patient records database, the Reporting Information System (RIS). We looked at a total of four patient electronic records on RIS and saw each record included comprehensive detail of the patients imaging history. We also saw imaging request cards were also scanned into the electronic patient records.
- The quality of patient referral forms was not audited across both sites.

- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and in use across the trust.
- Radiation risk assessments were entirely generic and reproduced across all imaging areas. They included information not relevant to Cannock Chase, for example, 'lead apron should be worn at all times'. This would be relevant to fluoroscopy rooms. There were only general x-ray rooms at Cannock. There was also a reference to a gamma camera which does not exist on-site.
- The radiation risk assessments were not fit for purpose and did not have enough specific detail for the radiation work undertaken in each area to include: the risk issue, an assessment of the risk and barriers in place to mitigate risk.

Safeguarding

Outpatients

- Records demonstrated that 91% of staff had received adult safeguarding training. 77% staff had received children's safeguarding training which was above the trust target of 75%.
- Staff we spoke with demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.
- Staff were able to access advice from the trust safeguarding team and the safeguarding policy was available on the intranet.

Diagnostic and imaging services

- We observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity for example Name, date of birth and GP.
- Identification checks on patients were carried out according to IR(ME)R. 20 forms were checked and all had been completed correctly.
- We spoke to three staff including administrative staff and radiographers and they were aware of their responsibilities to safeguard adults and children and on who to contact in the event of concern.
- Records showed that 100% of staff had received adult's safeguarding training. 100% of staff had received level I. However, when we reviewed documents supplied by the trust we found that for level II children's safeguarding records demonstrated that that both 0 and 27% of staff had undertaken the training. The figures were contained in the minutes of a governance meeting and in the provider information sent to the commission. 1% of the patients seen at Cannock Chase hospital were children.

Mandatory training

Outpatients

- Currently the mandatory training was offered course by course, individually at the New Cross site. The Staff would have preferred a whole day's training which covered all of their mandatory training requirements. There was a bus service linking the two sites which were eight miles apart.
- Trust records demonstrated 71% of staff within the outpatients department had completed their mandatory training. The trust target was 95%

Diagnostic and Imaging services

- All of the staff we spoke with told us they received on-going mandatory training and they were responsible for ensuring they kept up to date. Mandatory training included eLearning modules and face to face training.
- Records demonstrated that 63% of staff had completed their mandatory training.

Assessing and responding to patient risk

Outpatients

- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly and that staff signed to demonstrate that the equipment was checked and within the expiry dates.
- Processes were in place within the outpatients department to manage patients who presented at risk within the department. An on-call doctor was present on site to assess patients whose condition deteriorated during clinic appointments. For patients in attendance who had a cardiac arrest, the cardiac arrest team would be called and if patients required transfer to the emergency department at New Cross Hospital then a 999 ambulance call would be made.

Diagnostic and Imaging services

- The principal function of the Radiation Safety Committee was to ensure that clinical radiation procedures and supporting activities in the trust are

undertaken in compliance with ionising and non-ionising radiation legislation. The committee met twice each year and received reports from the appointed Radiation Protection Advisers, ensuring all recommendations were achieved.

- The manager told us that all modalities had appointed and trained Radiation Protection Supervisors (RPS), whose role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There was clear signage on the x-ray doors instructing the patients not to enter the x-ray rooms.
- The department (across both sites) had a procedure in place to check whether women were pregnant. Patients were asked the last menstrual period date (LMP) and if this was within 28 days for low-dose or 10 days for high-dose procedures then they proceeded with the examination. However professional bodies (the former Health Protection Agency, the Society of Radiographers and the Royal College of Radiologists) recommend that LMP is not routinely asked and those patients are asked, "Are you or might you be pregnant?" This avoided assumptions that females outside their dates were pregnant. The written procedure included an instruction to proceed with exposures if the patient said their husband had had a vasectomy. This had the potential risk of irradiating a pregnant woman if she answered 'yes' to her husband having received a vasectomy (and she might have had sexual intercourse with another partner).This was the same at the New Cross site.

Nursing staffing

- The general outpatients department was up to full establishment. No agency staff were used in this area. If shifts required covering, for example for sickness, they used their own staff on the nurse bank.

Medical staffing

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Medical cover was provided without the need for locum use.

Imaging and Diagnostic services

- There was a concern about staffing levels at Cannock Chase due to the increased workload from the additional orthopaedic caseload. The staff at Cannock did not rotate with staff at the New Cross site.
- Any staffing gaps were backfilled with their own bank staff.

Major incident awareness and training

Outpatients

- The staff we spoke with were aware of their roles in the event of a major incident.
- Major incident training was part of the trust induction mandatory training and policies were available to staff on their internal intranet.

Imaging and Diagnostic services

- Senior managers explained how table top exercises had been carried out to look at contingency plans to continue the service if the information technology systems failed.
- Emergency testing had been undertaken and a backup plan had been written.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Radiation risk assessments were generic in nature and not fit for purpose. Standardisation of referral forms in radiography was required to avoid confusion with using two different forms. There were regular delays in paediatric reporting.

None of the qualified nursing and 17% of unqualified nursing staff had received their appraisal in outpatients. Nursing staff within outpatients demonstrated limited knowledge of the Mental Capacity Act and Deprivation of Liberties.

Radiography and outpatients services were providing treatments in line with best evidence-based practice and NICE guidelines. Audits were being completed to ensure compliance with IR(ME) Regulations and NICE respectively.

Evidence-based care and treatment

Outpatients

- We saw that treatments across both sites were being provided in line with best evidence-based practice and NICE guidelines.
- Each speciality conducted audits to assess compliance with NICE guidelines in relation to their area of clinical practice.

Diagnostic and Imaging services

- NICE guidance audits were undertaken e.g. NICE guidelines for Fibroid conformity.
- The department have an Annual Audit Plan which was presented to us.
- It is a requirement of the IR(ME) Regulations for audits to be carried out to ensure safe exposure and practice. The audit plan did not include reference to IR(ME)R audit. However, during our examination audits had been completed to comply with IR(ME)R Regulations. It would be helpful if the audit plan clarified which audits related to IR(ME)R.
- There were nine reporting radiographers who had dedicated reporting time.
- On a needs basis, some reporting was outsourced. One radiologist said that quality checks had not been carried out on the reports provided by the supplier.
- The radiology consultants had monthly discrepancy meetings which were minuted and lessons shared and learnt.
- The department accepted two types of referral forms generated at Cannock and New Cross. The Cannock Chase referral form had clear sections for operators and practitioners to sign to prove that the various IR(ME)R functions had been undertaken and by whom; for example checking patient ID/checking pregnancy status/recording dose/operator affecting the exposure. The New Cross referral form did not have this information and the radiographers had adopted a different process to ensure compliance; for example ticking and signing patient details. Having two different styles of request forms may lead to confusion particularly at busy times.

Patient outcomes

Outpatients

- We discussed this with the Group Manager and matron for outpatients. They explained that each speciality discusses their figures at monthly governance meetings. One method they used to try and reduce this rate, was to inform patients by letter if their results were normal rather than bringing them back for another appointment. Some specialist nurses were also doing telephone follow-up appointments for example in gastroenterology and rheumatology. (This applied to both sites).

Diagnostic and imaging services

- The administrative staff checked the patient tracking list (PTL) daily prior to booking. Their rule was not to book over six weeks.
- There was a service level agreement in place with the clinical commissioning group (CCG) for GP reports – 90% of exams should be reported within 10 days. This was monitored on a weekly basis. 90% of examinations had been reported within 10 days and 95% within 15 days.
- The department had set their own internal key performance indicators (KPI's) for all other reporting – three weeks for outpatients and four-six hours for ward patents. The Clinical Director said that the outpatient KPI was not always achieved due to workload and staff shortage
- There were regular delays in paediatric reports. The Clinical Director indicated that there was not the level of interest in paediatric radiology within the consultant group to sustain effective report turnaround times. Consequently the turnaround times for paediatric reports were often several weeks. 1% of the patients seen in the department were children.

Competent staff

Outpatients

- Staff we spoke with told us that they had not received an annual appraisal.
- Trust data demonstrated none of the qualified nursing staff and 17% of unqualified nursing staff had received their appraisal in outpatients.
- Specialist nurses within the outpatients department provided nurse-led clinics alongside medical colleagues providing care for patients.
- In addition to mandatory training, nursing staff undertook training relevant to the clinic they were running, for example, wound care.
- Medical staff were given protected learning time to carry out training.

Diagnostic and Imaging services

Outpatients and diagnostic imaging

- All of the staff that we spoke to had received their appraisal. Trust data demonstrated that 100% of staff had received their appraisal.
- All staff reported that they had access to continual professional development training and that it was actively encouraged. The department held a training budget.
- The Medical Physics team annually updated IR(ME)R training for radiology staff and for new non-medical referrers.
- The Medical Physics team provided radiation protection supervisor (RPS) training for new RPS and also update training for existing RPS's.

Multidisciplinary working

Outpatients

- There was evidence of good multidisciplinary working across both sites within different speciality clinics. This meant that the results could be discussed and the results provided straightaway to patients.
- The ophthalmology team linked in with the diabetes and oncology teams in relation to diabetic eye disease and eye cancers.

Seven-day services

Outpatients

- The outpatient clinics ran within working hours Monday to Friday 9am -7.30pm.
- There were no out of hours waiting list clinics operated.

Diagnostic and Imaging services

- Radiology provided a service Monday to Friday 9am – 7.30pm,

Access to information

Outpatients

- Electronic access was available for pathology, microbiology and radiology results.
- Radiology reports were available electronically and results were e-mailed directly to the referring consultant.
- There was a trust target to ensure that GPs received letters within 48 hours of the patient's appointment. We saw evidence that this was being monitored and achieved within the outpatient department.

Diagnostic and Imaging services

- Radiology reports across both sites were available (across both sites) electronically and results were e-mailed directly to the referring consultant.
- Clinical Governance documents were not easily available to all staff (across both sites) as they were not filed on a shared drive. They were mostly held by the Clinical Governance lead.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Some nursing staff we spoke with demonstrated limited knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.
- We saw examples of accurately completed consent forms in records we looked at.
- Medical staff were aware of the Gillick competency. G**illick** competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Diagnostic and Imaging services

- Staff we spoke with demonstrated knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients receiving diagnostic procedures.
- Staff were aware of the Gillick competency with regards to gaining consent from children and young people.
- The majority of general x-ray procedures were carried out using implied consent from the patient.

Are outpatient and diagnostic imaging services caring?

Good

Patients spoke highly of the staff in both outpatients and diagnostic imaging. Patients described caring staff that were supportive and treated them with dignity and respect.

Outpatients and diagnostic imaging

We observed that staff were courteous, polite and friendly when responding to patient individual needs. Patients told us they were given good explanations of their treatments and were given sufficient time to ask questions.

Compassionate care

Outpatients

- We spoke with nine patients within general outpatients.
- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One mother told us they had received fantastic treatment and all the clinic staff had been lovely with her daughter. Another patient told us, "The doctors are brilliant and the nurses are good."
- All the patients told us that they were treated with dignity and respect.
- Staff we spoke with were aware of the chaperone policy. We observed that there were chaperone posters displayed in the general outpatients waiting area.
- We observed that staff were polite, courteous and friendly with patients.

Diagnostic and imaging services

- We saw staff being friendly and polite.
- Staff were courteous when caring for patients and were seen responding to patient's individual needs
- Patients told us that they were happy with the service provided by the receptionists and nursing staff.
- One patient said, "The nurse was wonderful, I couldn't fault her she was always checking on me."

Understanding and involvement of patients and those close to them

Outpatients

- Patients told us that they were given good explanations about their care and treatment**.**
- One patient told us, "The doctors always treat you with respect and they give you enough time to ask questions."
- Most patients told us they were kept informed about follow-up appointments via letters.

Emotional support

Outpatients

- We were told by patients the staff were supportive. One patient said, "The care is fantastic here."

Diagnostic and Imaging services

- One patient told us, "The people here are lovely."
- We observed a radiographer being very supportive to an elderly patient whilst preserving their privacy and dignity.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

There were long delays of up to an hour in outpatients and up to two hours in the radiography department. Patients were not always informed of delay times or reasons.

All patient information leaflets were in English. Information to request leaflets in alternative languages was written on the reverse of the leaflets but in tiny print that may well have gone unnoticed. Appointment letters were also only available in English.

There were no facilities in outpatients for staff to make food or drinks for patients. Within radiology there were no vending machines to provide food or drink.

Translation services were available for patients whose first language was not English. Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first.

Service planning and delivery to meet the needs of local people

Outpatients

- There was sufficient seating within the outpatients department for patients. However, there were no magazines to read whilst patients waited for their appointments. (This was the same across both sites).
- Appointment letters were only available in English. This was not representative of the local multi-cultural population.
- Patients said there were always problems parking. One patient told us they had arranged for a friend to give them a lift as they were aware of the parking issues.

Outpatients and diagnostic imaging

- We observed that it was difficult for receptionists to maintain patient's confidentiality due to the open plan layout within the reception area.

Diagnostic and imaging services

- Imaging services were commissioned by the clinical commissioning groups (CCG's) and the radiology department provided the baseline data for the service level agreement (SLA).
- The service met with the GPs on a six monthly basis to discuss service issues.
- There were no vending machines available within radiology to provide food or drink. A water fountain was available but was not clearly visible. We observed one patient in a wheelchair who was waiting for up to two hours with no access to water or food.
- There was a notice saying that there were two streams and other patients may be being seen first. Underneath this was a different notice saying that it might appear patients would be seen out of turn but this was not the case. There were signs informing patients mornings were busiest but this was not mentioned on the generic appointment letter.

Access and flow

Outpatients

- The referral to treatment percentage within 18 weeks non admitted pathway (between April 2013 and November 2014) was better than the standard and the England average.
- The percentage of cancer patients seen by a specialist within two weeks of urgent GP referral was better than the England average between January 2013 and September 2014.
- The percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was worse than the England average April - September 2014.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average April - September 2014.
- The Did Not Attend (DNA) rate was worse than the England average. The outpatient senior manager told us that they were about to introduce text messages (across both sites) to remind patients of their appointments to help to address this.
- There were no boards displaying 'delay times' within the waiting areas in the outpatients department. An orthopaedic clinic was running one hour late. We observed the nurse verbally updating patients about the delay. However, when we spoke to patients they said they were not usually updated with delay times.
- The appointments booking system was centralised at the New Cross Hospital. There had been teething problems when the trust took over the services at the Cannock Chase site. Staff informed us of an example where a whole clinic had been sent to the New Cross site when it should have taken place at Cannock Chase. These issues had been escalated to the appointments manager who was trying to address this.

Diagnostic and Imaging services

- We saw GP patients waiting over two hours for their x-ray. The reason given was that the patients from the outpatient orthopaedic clinic were given priority which then pushed back the GP patients in the queue. An elderly patient was waiting in a wheelchair with no access to food or drink. The service provision in this area needed reviewing to avoid the long waits.
- Some orthopaedic services had been transferred to Cannock Chase. Discussion with two managers indicated that radiology was not included in any service planning for the transfer, nor did radiology managers make plans to accommodate the service and impact on staffing levels.

Meeting people's individual needs

Outpatients

- The consultants within each speciality informed the appointments department how long was required for individual appointments depending on whether they were new or follow-up patients. The medical staff we spoke with said they were happy with the timing of the appointment slots.
- Vending machines were available to obtain snacks and drinks. There was a free water fountain for patients. However, none of the patients we spoke with were aware of it and there were no signs indicating its location.
- There was nowhere for staff to make patients food or drinks.
- Staff were able to borrow a hoist and bariatric chairs from one of the wards if required.

Outpatients and diagnostic imaging

- Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first.
- Staff received training on dementia and a consultant nurses in dementia and a lead nurse in learning disabilities were available to provide advice (based at New Cross).
- There was an alert system on the electronic appointment system which should flag if a patient required a translator when booking their appointments. This enabled translators to be booked in advance for patients appointments. A telephone translation service was also available for staff to aid communication with patients whose first language was not English.
- All the patient information leaflets were in English. In very tiny print on the back of these leaflets was a sentence (in different languages) saying that leaflets could be requested in alternative languages. However the print was too small for most patients to notice this. This did not reflect the multicultural population that the hospital cared for.

Diagnostic and imaging services

- If information was provided at the point of booking an appointment, the booking administration team avoided early morning, late afternoon or mobile unit appointments for vulnerable adults and children, including elderly patients (across both sites).
- Since the trust secured the Cannock Chase imaging services, the ultrasound lists were booked at Wolverhampton. Wolverhampton patients were sent appointments at Cannock. An increase do not attend (DNA) was noted, on average 22% DNA rate. This had not been investigated to see if it was attributable to the new location and distance travelled. Patients were not contacted prior to booking appointments at Cannock.

Learning from complaints and concerns

Outpatients

- Most patients we spoke with did not know how to make a complaint.
- We did not see any posters or leaflets explaining how to make a complaint.
- The complaints they received were discussed at monthly governance meetings and then fed back to staff at their team meetings. We saw minutes of these meetings and staff confirmed that learning from complaints was fed back to them. Staff told us the majority of complaints were around cancellations and waiting times at the clinics.

Diagnostic and Imaging services

- Patients were telephoned to establish the reason for their complaint and to ensure all of their concerns were responded to.
- Complaints and outcomes were discussed at the monthly Clinical Governance meeting.
- Staff were requested to provide statements if involved or mentioned in a complaint. However, the same staff did not see the final response letter.
- Staff told us they did not receive feedback of lessons learned from themes of complaints.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was a lack of a clear vision and strategic planning in both outpatients and radiography.

Staff within outpatients did not feel supported by the senior managers at the New Cross site.

There was a lack of patient feedback to improve services within the radiography department.

There appeared to be a lack of senior management support to empower staff to make changes and drive improvements within both outpatients and radiography.

There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Vision and strategy for this service

Outpatients

- Local leadership were not aware of the Royal Wolverhampton future vision and strategy for outpatients.

Diagnostic and Imaging services

- There was not a clear strategy and vision for the radiology service.
- There was little evidence of strategic planning of the services. For example planning for the orthopaedic services at Cannock Chase had not been discussed with radiology managers to address the impact on staffing.

Governance, risk management and quality measurement

Outpatients

- There was a structured governance system in place.
- Monthly governance meetings took place which discussed the risk register, complaints and incidents, lessons learnt and actions to take in future and audits. We saw minutes of these meetings.
- The risk register did not include issues about addressing waiting times in clinics.
- A protocol had been introduced (across both sites) to ensure the right patient went into the right room as a result of an incident whereby two confused patients went into the wrong clinic room. Staff we spoke with were aware of the learning from this incident.
- Corporate governance officers also attended these meetings to share lessons learnt in relation to incidents in other areas of the trust.

Diagnostic and imaging services

- Despite clear governance structures the governance was not effective.
- The risk register was well managed with regular review – however the department managers did not seem empowered to identify and report risks within their areas. For example, a senior radiographer was not aware that they could formally raise risks on the department risk register.
- The issue regarding GP patients having to wait excessive times for x-rays due to outpatients being prioritised was not on the risk register.
- The governance systems had not highlighted the shortfalls with protocols and risk assessments specified within this report.
- There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations. There was no clearly defined structure of roles and responsibilities within the department.
- We informed the trust post-inspection of IR(ME)R concerns (across both sites). We have since had assurance from the trust that these matters have been addressed.

Leadership of service

Outpatients

- Staff we spoke with felt supported by the sister within the outpatients department. However they said there was very little support from the senior management based at the New Cross site. They told us that the senior management rarely visited the Cannock site.
- Staff felt the department would benefit from a matron being on-site.
- The directorate manager and matron of outpatients felt well supported from the executive team. They reported good two-way communication between the department and the board.

Diagnostic and imaging services

- Staff told us they were happy working for the trust and felt supported by the management team.
- Few staff could say who the directorate management team were.
- The senior radiology management team reported that they felt really supported and listened to by the executive board. The clinical director said that the chief executive was always willing to listen with a good line of communication to the board.
- The management structure was not clear to all staff. Two senior staff were asked who the superintendent radiographer was line managed by. Responses were vague and there was not a clear concise response to the question.
- Discussions with senior staff (such as superintendent radiographers and radiologists) highlighted that they were not involved with business planning and that any plans were not shared.

Culture within the service

Outpatients

Outpatients and diagnostic imaging

- Staff we spoke with felt that the Cannock department was not valued by the senior management at the New Cross site. They felt that systems and protocols had been imposed on them with little consultation about the changes.
- Staff told us they did not feel supported by senior managers to make changes they wanted to make. For example, a patient survey had previously been conducted prior to the trust taking over Cannock Chase Hospital. Staff said they did not feel they could recommence this without permission.
- However, staff described a friendly department with a good working atmosphere.

Diagnostic and Imaging services

- All staff that we spoke with were happy working for the Trust.
- Staff told us there were good working relationships and a positive working environment.

Public and staff engagement

Outpatients

- A patient feedback board was displayed in the waiting area of outpatients. Patients were encouraged to write both positive and negative feedback on slips of paper and then pin them to the board. All the comments were very positive about the care received. Negative comments related to the poor parking and waiting times to see the doctor.

Diagnostic and Imaging services

- The manager told us that there were no local audits of patient satisfaction for example patient surveys.
- There were no patient 'comment' boxes within the radiology departments.

Innovation, improvement and sustainability

Outpatients

- We discussed with the sister areas of innovative practice that had been implemented within the outpatients department.
- They were proud of their patient information displays such as those on dementia, eczema and osteoporosis.
- The department had developed links with the local special-needs school and displayed pictures done by the children. They encouraged the children to come and see their work within the department.

Diagnostic and Imaging services

- Business plans and service improvements for other specialities were not shared with radiology (across both sites). The department was therefore not able to plan for development of services and impacts on resource and diagnostic targets. This also applied to business cases for additional medical or surgical consultant posts.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Minor Injuries Unit

1. The trust must put in place effective systems to monitor outcomes for patients.

OPD & Diagnostics

1. The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
2. The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations.

Action the hospital SHOULD take to improve

Minor Injuries Unit

1. The trust should improve risk management for the MIU including demonstrating how it has assessed and how it safely manages the lack of access to x ray facilities for patients and the lack of privacy at the reception desk.
2. The trust should improve the uptake of mandatory staff training at the MIU and provide staff with dementia awareness training.
3. The trust should support the MIU service to monitor outcomes for its patients including those transferred to the ED, and to provide key performance indicators, including waiting times, and other access and flow indicators.
4. The trust should effectively communicate a clear vision for this service.
5. The trust should strengthen Governance arrangements to support continuous improvement and manage risk strategically and more effectively.

Medicine

1. The trust should ensure that broken equipment is fixed in a timely manner.
2. The trust should ensure that all equipment such as nutrition feeding equipment pumps are portable appliance tested (PAT).
3. The trust should ensure that the protocols be documented regarding wound care.

Surgery

1. The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
2. The trust should have in place a major incident plan for all the services. Staff should be aware of this plan as it relates to their specific service.
3. The trust should make sure that there are process in place to ensure formal “sign in” takes place in the anaesthetic room.
4. The hospital should ensure operating lists are published in a timely manner.
5. The trust must make sure that the integration of the service is undertaken by engaging clinicians at all levels in an inclusive manner.

OPD Diagnostics

1. The trust should ensure that all staff receives post-incident feedback, shared learning and changes in practice related to incidents.
2. The trust should ensure that all staff receives safeguarding training in the protection of vulnerable adults and children.
3. The trust should ensure that the procedure to check whether women were pregnant prior to receiving radiography tests is improved to be in line with professional body guidance.
4. The trust should ensure that the disabled cubicle in radiography is improved to ensure the call bell and curtain is fit for purpose.
5. The trust should improve radiation risk assessments to ensure they are fit for purpose.
6. The trust should standardise radiology referral forms and ensure that they adequately record the information required by IR(ME)R.
7. The trust should ensure that all staff in outpatients receives their appraisals.

Outstanding practice and areas for improvement

8. The trust should try to improve waiting times in outpatients and radiology and keep patients informed of delays.
9. The trust should ensure that appointment letters and patient information leaflets are accessible in languages other than English.
10. The trust should ensure that there are facilities to provide food and drink to patients in outpatients and radiology.
11. The trust should ensure that senior management support and empower staff to make changes and drive improvements within both outpatients and radiography.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good Governance** 17.— 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; **In that the trust had insufficient effective systems in place to monitor outcomes for patients.** **The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements in MIU, the strategy, plans or the information used to monitor performance. The service had an incomplete picture of patient experience, outcomes and its own effectiveness.** **Governance systems had not highlighted shortfalls in risk assessments and protocols in Outpatients and diagnostics. There was not clear ownership of responsibilities to ensure the radiology departments was working within best practice professional guidelines and IR(ME)R regulations.Regulation 17 (2) (b)**