Care Quality Commission

Royal Wolverhampton NHS Trust

Royal Wolverhampton NHS Trust

Quality Report

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

Ratings

Overall rating for this hospital	
Accident and emergency	
Medical care	
Surgery	
Intensive/critical care	
Maternity and family planning	
Services for children & young people	
End of life care	
Outpatients	

Summary of findings

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Summary of findings

Overall summary

The Royal Wolverhampton NHS Trust is an acute services provider with three main sites and a total of 800 beds, including 27 intensive care beds. The trust has one main acute hospital site: New Cross Hospital. The Phoenix Walk-in Centre and West Park Rehabilitation Hospital are the other sites. The trust is the largest teaching hospital in the Black Country, has an operating budget of £374 million, employs 6,800 staff and in 2011/12 treated more than 700,000 people.

The trust's Board has had a number of member changes in the last 18 months, including the Chair, Chief Operating Officer and several non-executive directors. New Cross Hospital has been inspected six times since registration in April 2010. The trust was meeting CQC standards at the last inspection in January 2013.

We inspected this trust as part of our new in-depth hospital inspection programme. It is being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that Royal Wolverhampton was a medium risk trust.

Before visiting, we looked at a wide range of information we held about the trust and asked other organisations to share what they knew about it. We carried out an announced visit on 26 and 27 September 2013, and during that visit we held focus groups with different staff members from all areas of the hospital. We looked at the personal care or treatment records of patients, observed how staff were caring for people and talked with patients, carers, family members and staff. We reviewed information that we asked the trust to provide. We also held a public listening event where patients and members of the public shared their views and experiences of the trust.

The trust has performed well on the NHS 2012 Inpatient Survey and Inpatient Friends and Family Test, which was supported by positive feedback from patients during the inspection who felt that overall care was responsive and provided in a sensitive and dignified manner, specifically, feedback from patients in the outpatient clinics, and parents in the children's care ward, was very positive.

Staff largely held positive views of the leadership of the trust, and felt supported in their roles with good access to training.

The trust has reported five 'never events' of retained swabs or similar incidents since August 2012, which is slightly higher than trusts of a similar size. The review team looked at the systems and processes in place to minimise 'never events' and noted evidence of good practice such as implementation of World Health Organisation checklists. It was also noted that the trust had taken steps to improve the leadership of cardiothoracic theatres and had brought them all under the same management structure.

We identified a number of areas where the trust requires improvement:

- The hospital must take action to improve the responsiveness of care for older patients. We were concerned that older people's care, surgical and dementia wards were not sufficiently staffed, particularly at night, where there was one registered nurse for every 10 patients. We felt this was impacting the safety and effectiveness of care. The trust must also ensure its dementia care bundle is implemented consistently on every ward.
- The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence. This issue has been included on the trust's risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas. Further work is needed to improve staffing levels in the maternity ward, as it is impacting on the responsiveness and effectiveness of staff.
- There were a number of instances across the hospital where processes and systems had not been properly followed. These included infection and hygiene controls, responding to patient alarms, and following guidelines for treatment of patients with dementia.
- During our inspection we saw examples where systems and processes intended to help people at the end of their life were not fully implemented – particularly relating to documenting decisions made about whether to resuscitate a patient.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

The trust has reported five 'never events' (a patient safety incident that should never occur) since August 2012. The trust realises this is an area for improvement, and has demonstrated the steps it has taken as a result and services are considered to be safe.

A number of systems and processes have been implemented to improve safety, including the 'VitalPAC' patient observation system, which support the provision of safe care. Strong risk assessment and incident reporting practices were noted across the hospital.

The trust needs to improve its staffing levels on older people's care wards and surgical wards and in maternity services to ensure safety.

Are services effective?

The hospital has as a clear focus on patients and good clinical outcomes. However the inspection team observed instances where older patients were not receiving effective care, and examples where systems and processes intended to help people at the end of their life were not fully implemented – particularly relating to documenting decisions made about whether to resuscitate a patient.

Are services caring?

Patients and their relatives were positive about the staff working on the wards, and the care they received. Numerous examples were noted where patients felt cared for. Patients said that staff were sensitive to their needs and delivered care in a dignified manner. Strong positive feedback was received from parents in the children's care department, and from patients in the outpatient clinics. Overall services were considered to be caring.

Are services responsive to people's needs?

The trust performed well against some national targets and surveys, including:

- Patients being seen within four hours in the A&E department.
- The frequency of cancellation of operations was within the national average.

There were deficiencies in the trust's complaints system, particularly publicising the process for making a complaint to patients and their relatives. The trust needs to make improvements to its complaints system to make this more effective.

In the majority of inspected services, the trust does not have systems in place to respond to the needs of people with learning disabilities. This needs to be an area of focus going forward.

Summary of findings

Are services well-led?

The trust's leadership team has been through a number of changes in recent years; notably the Chair was appointed in March 2013. The Chief Executive and the Chief Nurse have been in post since 2004 and 2005, respectively, bringing some stability to the leadership team.

The trust scored in the top performing 20% for 10 of the 28 indicators on the NHS staff survey, and generally staff across the organisation had a positive view of the trust's leadership team.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Staff were caring and responsive to people's needs. Patients and relatives were positive about their care and spoke highly of the staff. Staff had a positive approach to providing care in an environment that was experiencing increasing demand, given that a neighbouring hospital's accident and emergency department operated restricted hours. This additional demand had impacted on the responsiveness of the department, but the trust had put in place plans to extend the department to cope with the extra pressure. Although we observed an emphasis on quality, we had some concerns regarding the leadership of the department and how it communicated key messages and lessons it had learned.

Medical care (including older people's care)

The hospital must take action to improve the responsiveness of care for older patients. We were concerned that elderly care and dementia wards were not sufficiently staffed, particularly at night, where there was one registered nurse for every ten patients. We felt this was impacting the safety and effectiveness of care. The trust must also ensure its dementia care bundle is implemented consistently on every ward.

The trust had systems to manage the safety of patients on the medical wards. Staff knew how to report serious incidents and told us that the trust learned lessons from any feedback provided. There were systems to monitor the needs of patients, and there was evidence that the trust was responding to these needs. The trust routinely reviewed the quality of care, and we saw evidence that it responded to the findings of these reviews.

Ward staff told us about specific changes they had made to make services more effective. They displayed a caring and sensitive approach to patients and relatives, but we were concerned about two isolated incidents where staff failed to respond to call bells in a timely manner.

There were specific examples of the trust developing systems and services to ensure that it met people's needs. For example, it has developed a dementia ward. However, for patients not on this ward the trusts dementia care bundle was not fully implemented and we were concerned about the levels of staffing on some of the elderly care wards. Protected meal times and the system for helping patients to eat and drink was not consistently applied across the hospital.

Surgery

Patients and staff said that wards were well staffed by day and patients felt well cared for. However, they felt they did not have enough staff at night.

Summary of findings

Patients told us they had to wait for pain relief sometimes as a result. Staff on some wards said that staffing levels at night did not enable them to run their wards safely. The trust was aware of this issue and had taken steps to address it.

In theatres we noted the efforts made by the leadership team to address the issue of Never Events and develop an open safety culture. There were systems in place to ensure service were safe and we observed a positive culture in theatres regarding the reporting of incidents. There were some initiatives in place to make treatment effective. For example, there were specialist doctors for people who had dementia and had been admitted with bone fractures.

Staff on the ward told us that they were well-led and that senior management within the hospital were visible and wanted to know about patients' care.

Intensive/critical care

We found that the intensive care and critical care unit was a safe and effective service. It was responsive to the needs of its patients and had caring staff. We found that the unit was well-led and that communication was effective across the multidisciplinary teams that worked within it.

Maternity and family planning

The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence, this issue has been included on the trust risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas.

There were systems in place to ensure patient's safety. This included the management of staffing levels and skill mix to ensure that sufficient staffing was available to meet patients' care and treatment needs. However, people raised concerns that a shortage of staff had meant that not all patients had received regular postnatal home visits from midwives after being discharged.

Services for children & young people

Parents told us that they were happy with the care and treatment that the hospital provided. They told us that staff listened to them and treated them with respect. They also said that staff were available when they needed them. They told us that they were actively involved in delivering their child's care. Most parents told us that communication between staff and them was good.

On arrival at the hospital, staff assessed patients' needs in an appropriate and timely manner. They planned and delivered care and treatment in line with patients' individual needs.

Systems were in place to ensure patients' safety. This included the management of staffing levels and skill mix to ensure that sufficient staffing was available to meet patients' care and treatment needs.

Overall, there were effective systems in place to reduce the risk and spread of infection. However, we noted some concerns in relation to poor hand hygiene and the cleaning of the toilets on the children's care ward.

Summary of findings

The trust did not employ a specialist to specifically support children with learning disabilities.There was one full time person who supports adults and children across all departments in the trust. This meant that staff with the specific skills to provide care and support to this group of patients may not be available when needed.

End of life care

Staff were caring and sensitive to patients' needs. The trust had a specialist palliative care team who supported staff on the wards providing end of life care. Almost all patients referred to the service were seen on the day of referral. Staff spoke highly of this support and felt this teamwork helped them to provide safe care. However, staff did not always complete documentation, which meant that patients' wishes might not always be followed. The trust acknowledged that there were still improvements to be made to end of life care, and it had developed a strategy to support this.

Outpatients

The main outpatients environment was not as welcoming as other parts of the hospital. There was limited information and facilities for patients. We were also concerned about the cleanliness of some parts of the department. Outpatients had not had a substantive matron in post for over six months, however, the trust told us that regular support had been offered by another matron. The trust had removed one band seven nurse as part of a cost improvement programme. Two part-time band six nurses had been running the department. The part-time band six nurses told us they had received limited support over this time period.

Despite this, patients and carers were overwhelmingly positive. They felt that the appointment system was effective and that appointments are rarely cancelled. Although we were told that clinics can often over-run. Many patients talked about problems with parking and how this can impact on their ability to arrive on time for their appointment.

Summary of findings

What people who use the trust's services say

The Royal Wolverhampton NHS Trust performed well in the 2012 Adult Inpatient survey, which is backed up by slightly better than average inpatient performance in the Friends and Family Test.

Areas for improvement

Action the trust MUST take to improve

- The hospital must take action to improve the responsiveness of care for older patients. We were concerned that older people's care, surgical and dementia wards were not sufficiently staffed, particularly at night, where there was one registered nurse for every 10 patients. We felt this was impacting the safety and effectiveness of care. The trust must also ensure its dementia care bundle is implemented consistently on every ward.
- The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence. This issue has been included on the trust risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas. Further work is needed to improve staffing levels in the maternity ward, as it is impacting on the responsiveness and effectiveness of staff.

Action the trust COULD take to improve

- Infection and hygiene controls
- Following guidelines for treatment of patients with dementia
- Documentation of decisions made about whether to resuscitate a patient
- Responsiveness to patient feedback
- Clear focus at Board level on a short to medium-term improvement strategy

Good practice

Our inspection team highlighted the following areas of good practice:

- Patients praised staff on their caring and compassionate approach, and staff spoke positively about working for the trust.
- The inspection team was impressed with the trust's response to the never events in theatres and the steps taken to minimise the likelihood of them reoccurring.

Royal Wolverhampton NHS Trust

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Liz Redfern, Chief Nurse, NHS England South

Team Leader: Debbie Widdowson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant surgeons, physicians and junior doctors, senior nurses and a student nurse, an allied health professional and a hospital manager. The team also included four people representing the public and patients.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new surveillance model. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Royal Wolverhampton NHS Trust was considered to be a medium risk service.

How we carried out this inspection

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

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

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

Detailed findings

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

Before visiting, we looked at lots of information we held about the trust and asked other organisations to share what they knew about it. We carried out an announced visit on 26 and 27 September 2013, and during that visit we held focus groups with different staff members from all areas of the hospital. We looked at the personal care or treatment records of patients, observed how staff were caring for people and talked with patients, carers, family members and staff. We reviewed information that we asked the trust to provide.

We also held a public listening event where patients and members of the public shared their views and experiences of the trust.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

The trust has reported five 'never events' (a patient safety incident that should never occur) since August 2012. The trust realises this is an area for improvement, and has demonstrated the steps it has taken as a result and services are considered to be safe.

A number of systems and processes have been implemented to improve safety, including the 'VitalPAC' patient observation system, which support the provision of safe care. Strong risk assessment and incident reporting practices were noted across the hospital.

The trust needs to improve its staffing levels on older people's care wards and surgical wards and in maternity services to ensure safety.

Our findings

Minimising never events

Between August 2012 and July 2013 the trust reported four never events, a slightly higher level than trusts of a similar size. A few weeks before our inspection, there was another never event involving the same consultant and theatre (in gynaecology) as one of the previous four events. The investigation for this event was ongoing at the time of the inspection.

We looked at what systems and processes the trust had in theatres to minimise the occurrence of never events. World Health Organisation (WHO) checklists had been implemented in all theatres, and these were regularly audited, which demonstrated good practice. The results of these audits were displayed in each theatre. There was a clearly defined safety culture, and this was evident in the behaviour of the staff. We were told that the cardiothoracic theatres had up until recently been run separately from the main theatres. At the time of the inspection, the trust had brought these theatres under the same management structure to ensure consistent standards across all the theatres.

Cleanliness and infections

Wards and public areas were generally clean and free from clutter, but there were a number of lapses. For example, in the paediatric unit the toilets were not cleaned for over 24 hours. In outpatients the environment appeared to be clean, but we found that some clinical trollies were dusty and some high surfaces were not clean. The cleaners room was dirty and we were concerned as to how staff can maintain levels of cleanliness

The trust's infection rates for MRSA and MSSA were both statistically better than expected, while the C. difficile rate were in line with the expected number. Between July 2012 and June 2013, the trust had one case of MRSA and 19 cases of MSSA. In the same period it had 39 cases of C. difficile. The trust told us that reducing and controlling infection rates had been one of its major challenges in recent years, and it was proud of the results it has achieved.

Staffing

The trust told us that staffing was an area for improvement and that it was aware where staffing levels were an issue. The key areas of concern were maternity, paediatrics and care of the elderly.

The trust told us that it had a shortage of midwives, and it had closed a recently opened midwifery-led unit because of unsafe staffing levels across the rest of the maternity unit. The trust did have plans in place to address this shortage, and it had included this issue on its risk register. However, it was still concerned about delays within the maternity triage unit and the availability of midwives for home visits. There were plans to recruit additional midwives, and the trust had recently appointed several; pre-recruitment checks were in process at the time of the inspection. The trust had also recently appointed several healthcare assistants. There was an escalation process (a process for reporting an issue to management) for situations where there were not enough staff available to provide safe care and treatment, and there were guidelines for staff on the action they should take. Senior staff had a good understanding of the escalation process, and the trust reviewed the staffing levels against the demands of the service on a daily basis.

In paediatrics, recruitment plans were in progress, and a number of new staff had recently been appointed. A 'bank' of staff (staff who work to fill any gaps in the rota) had also been introduced. We were told that the staff on the bank rota were all registered paediatric nurses. An escalation process was also in place, and it was being used during our visit: the paediatrics unit was accepting no further admissions at that time to ensure patient safety.

Are services safe?

Staff and patients also reported that staffing levels on the surgical wards at night created difficulties in providing safe care. Patients commented that they had to wait at night for pain relief. The trust told us they were aware of this issue and had already taken steps to remedy this.

We were concerned that the elderly care and dementia wards were not sufficiently resourced, especially in the evening and at night. There was one registered nurse for every ten patients. The wards were very busy, it was a challenging environment and staff were only able to deliver the basic care requirements.

Mental health patients

The accident and emergency department had a room for treating patients with mental health issues whose behaviour put staff or other patients at risk. The room was intended to keep the person safe while they waited for staff from the mental health trust to attend. We had concerns as to how staff entered and exited this room and maintained their safety. We were also concerned that placing a patient in this room could be a restriction of their liberty.

Pressure ulcers

The percentage of patients with new pressure ulcers at the trust had fluctuated either side of the national rate over the previous 13 months, reaching its highest point (2.2%) in September 2012. This trend was mirrored in the over 70s age group. The Chief Nursing Officer believed that this was because measures to increase accountability had improved staff awareness of the issue. Nurses responsible for the patient area are held to account by the Chief Nursing Officer, who asks them to present a 48-hour root cause analysis report. She believed this had improved care for patients. Staff described this approach as "uncomfortable, but [we] can see the point".

Venous thromboembolism

The percentage of patients with a venous thromboembolism (VTE: blood clot) had been below the national average in all but five months of the previous 13 months. However, most recently the trust's rates had been increasing, culminating in a June 2013 figure of 5.1%, which was a significant variation from the national rate. If treatment for a VTE was started after a patient was admitted to the service, the hospital counted it as a new case. The percentage of patients with a new VTE case was below the national rate for the first eight months of the previous 13, but then it had matched or exceeded it in last five. Some consultant staff felt that increased awareness had resulted in an increase in reporting, other evidence did not point to this reason.

The trust provided us with an analysis of the causes of 75 hospital associated VTE cases from January to June 2013. This analysis was incomplete, but it did show that in some cases late, inadequate or no risk assessment was a contributing factor. There was evidence that the trust Board was aware of the rise in VTE and had discussed it at the Quality and Safety Committee, where the Chief Nursing Officer had highlighted the upward trend in VTE. However, ensuing discussions focused on the validity of the data and not the reasons for the increase. So it was not clear what actions the trust had taken.

Urinary tract infections

In the 13 months prior to the inspection, the rate of catheter use and urinary tract infections (UTIs) had been below the national average. But in July 2013 it exceeded the national average (at 0.51%). There was a similar trend of increasing catheter use and UTIs for the over 70s patient group.

The July 2013 Integrated Quality and Performance Report stated that the trust-wide Continence Team was now in place across the acute and community sectors. It also said that the trust expected an improvement in UTIs over the next few months, due to improved education and training in the importance of catheter management and removal.

Are services effective?

(for example, treatment is effective)

Summary of findings

The hospital has as a clear focus on patients and good clinical outcomes. However the inspection team observed instances where older patients were not receiving effective care, and examples where systems and processes intended to help people at the end of their life were not fully implemented – particularly relating to documenting decisions made about whether to resuscitate a patient.

Our findings

Mortality rates

The trust said that its committees regularly monitored data published by Dr Foster Intelligence (which helps healthcare organisations monitor their quality and effectiveness). It also said it investigated and followed up any alerts. The trust had developed its own system for investigating diagnoses and procedures with a higher than expected death rate before they reach the alert threshold. Investigations involved reviewing case notes and carrying out a detailed analysis. The medical director was working towards a system where every death is reviewed, but we are not clear what the timescales were for this. A review of every death was already happening in some directorates. Consultant staff demonstrated that they were engaged with these processes.

Elderly care

Between 2010 and 2012 the trust had eight mortality alerts, including five for 'complex elderly' patients admitted as an emergency. Subsequent case note reviews identified problem areas that were particularly applicable to 'complex elderly' alerts:

- Poor clinical handover
- Failure to act on early warning scores
- Delays in investigations, diagnosis and treatment
- Palliative care pathway not being used
- Inappropriate admissions due to patients' frailty and severity of illness.

We found that some of these problems were still occurring on wards where elderly patients were cared for. Ward C22 is a dedicated dementia unit. It was described as a centre of excellence, and we did see some good practices during our visit. A clear pathway (called a 'dementia bundle') had been developed for elderly patients. But although many patients were on this care pathway, for some patients on the wards for care of the elderly it was not implemented. For example, we found one patient who should have been referred to a tissue viability specialist, but this had not happened. There were 20 'dementia champions' across the trust whose role it was to expand best practice from the dementia ward to other areas of the trust, but this had not happened nine days after the initial request for rollout had been made. The lack of a clear systematic roll-out plan was disappointing, especially as we found other examples of this (for example, see the section on end of life care).

Feedback from patients at the listening event described ineffective care on the elderly and dementia wards, and included examples of lack of pain relief, poor communication and patients' falls.

Premises

This year's change of signage across the hospital had caused confusion. In some areas, information for patients and relatives made reference to a ward or department's old name/number. Some patients and relatives said that the changes had made it difficult for them to find their way around the hospital and that there was not enough information around the site to help them. People at our listening event told us that the trust had consulted on the changes but appeared not to have taken action on feedback from the public.

Accident and emergency

Senior managers at the trust all described accident and emergency (A&E) as one of their key risk areas. The existing department was built to serve approximately 70,000 patients per year, but the trust said that demand was now 40,000 over that figure. It acknowledged that the department was not fit for purpose, and a £2.5 million extension was due to open three weeks after our inspection, increasing capacity. To release ambulances, the department will care for patients in a corridor area next to the main department and make sure that it has adequate staffing to monitor and care for these patients. Despite these challenges, the trust has been meeting the A&E four-hour waiting target, and feedback from patients and relatives was generally positive.

End of life care

We looked at documentation relating to do not attempt resuscitation (DNAR) orders (which tell staff that a patient

Are services effective?

(for example, treatment is effective)

has said they do not want to be revived if their heart stops beating or they stop breathing). We were concerned about the quality of this documentation and the risks this could pose to patients. It is important that patients and carers make informed choices, and that the decisions are communicated efficiently and effectively. This requires a partnership approach between the doctors and the people involved to ensure that shared decision-making takes place. Only one out of 20 records we looked at was completed correctly. At the time of the inspection, the trust did not routinely audit these records, only as part of a records audit required by the NHS Litigation Authority (NHSLA).

We looked at how effectively staff cared for patients' relatives. People who attended our listening event told us that they felt the trust did not break bad news very well. Many people said they were told bad news on the ward, in an unsuitable environment. In addition, the bereavement office was not conducive to offering support. There was no bereavement officer or service to support bereaved relatives or junior doctors. We were told that the trust had set up a group to review how the trust managed bereavement and that this included visiting other hospital sites. But the trust had not made any further progress in this area.

Complaints

The trust had received over 170 written complaints since April 2013. All complaints (whether verbal or written) were handled in the first instance by PALS, which decided how a complaint was going to be responded to. For example, a patient may have written to the chief executive but PALs could decide that the response should come from another member of staff. The trust's policy on managing complaints does not specify a timescale for responding to complaints, but it did monitor its performance against a deadline of 25 working days. Performance against this target was reported to the trust Board. In the report for August, the trust hit this target for only 48% of complaints that month; in the previous month the trust achieved this target for less than 40% of complaints. This means that the trust did not respond to people's comments and complaints in a timely manner.

There is very limited information for patients and members of the public regarding how to complain if they are unhappy with the care they received. For example, we did not see any posters or notices in the outpatients department. Although some areas did display information relating to the PALs service, it was not always clear that this is the route for patients wanting to complain.

Hardly any of the patients we spoke to told us that they knew how to complain about the trust if they wanted to. At our listening event some people told us they felt that PALs was complicit and not helpful in the complaints process. Some people were also unhappy with the process: some people felt that responses took too long and others said letters had gone to the wrong address.

Are services caring?

Summary of findings

Patients and their relatives were positive about the staff working on the wards, and the care they received. Numerous examples were noted where patients felt cared for. Patients said that staff were sensitive to their needs and delivered care in a dignified manner. Strong positive feedback was received from parents in the children's care department, and from patients in the outpatient clinics. Overall services were considered to be caring.

Our findings

Meeting nutritional needs

The trust had a protected mealtimes policy, which meant that all non-urgent clinical tasks stopped for a period of time so that patients could eat their meals without rushing. We saw this on all of the wards we visited. The range of food covered many tastes, restricted diets and different cultural needs. Food was presented in an appetising manner, including for patients who were restricted to a soft diet. Patients said that the food was good. They told us there was plenty of choice and the quantity was always sufficient. Hot and cold drinks were freely available on the wards.

The trust had a number of systems operating that alerted staff to the patients on the wards who required assistance with eating and drinking. This included the "SafeHands" electronic system and safety briefings on the wards. These systems were not applied consistently or effectively across the hospital. For example, there were wards caring for elderly patients; one had implemented the system and the other had not. On one elderly care ward patients with support needs got their meal after other patients, so that staff could help them immediately, when their food was hot. This meant that patients on this ward had their nutritional needs met. However, on the other elderly care ward we saw a patient get their meal at 5pm and a nurse came to help them eat it at 5:55pm, by which time the meal was cold and the patient did not want to eat it. This meant their needs were not being met.

Involving patients in their care

Most patients, relatives and friends were positive about the staff. Many told us they found the staff "caring", "compassionate", "friendly", "helpful" and "supportive". Patients also said they felt informed about their care and treatment and that the staff listened to them and understood their concerns. However, we did find some examples where patients and carers did not feel involved. On the many wards we visited, we found that staff were generally caring and considerate towards patients and there was a strong sense of purpose in many of the teams.

We were concerned about the trust's ability to care for relatives after a person died. We visited the bereavement office and mortuary viewing room. The office was business-like and lacked a welcoming and peaceful ambiance. The viewing room was clinical and uni-faith. It did not demonstrate a compassionate setting for relatives at a time when people's emotional state needs to be considered. We were told that the staff in the bereavement office had no specific training for the role.

At our listening event, many patients shared positive experiences, but there were also some examples of poor and uncompassionate care. Patients said they were discharged too early and without medication. There were stories of patients being moved from ward to ward without their family being informed. In one case, the ward spent hours trying to locate a terminally ill patient, as staff had no idea where he had gone. Many people commented on the lack of communication between the trust and patients: there were patients and families who were not informed about what was happening. There were also a number of examples of poor practice, including long waits for pain relief, staff not meeting patients' nutritional needs and a lack of compassion or a poor attitude among staff. Many of the people we spoke with said they felt there were not enough nurses and midwives on the wards.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust performed well against some national targets and surveys, including:

- Patients being seen within four hours in the A&E department.
- The frequency of cancellation of operations was within the national average.

There were deficiencies in the trust's complaints system, particularly publicising the process for making a complaint to patients and their relatives. The trust needs to make improvements to its complaints system to make this more effective.

In the majority of inspected services, the trust does not have systems in place to respond to the needs of patients.

Our findings

Discharging patients

Some medical wards had discharge support coordinators. Ward staff told us these coordinators helped them to ensure the discharge process ran smoothly. Staff based in the discharge lounge also helped the wards and were proactive in managing effective discharge. There was also a discharge lounge in the maternity unit which enable staff to release beds for patients to be admitted to which still ensure effective discharge. Some patients told us they did not like the discharge lounge and did not like waiting there.

Friends and Family Test

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS Friends and Family Tests for Accident and Emergency and Inpatient admissions. At the time of the inspection, Wolverhampton was performing at the national average score on the Inpatient test but below the national performance level on the Accident and Emergency score. Of the 30 wards at Wolverhampton included in the July Inpatient survey, 12 scored below the trust-wide average of 75%.

We noted on the wards that there was limited information about these tests and the results. One ward we visited had some data on a notice board, but it was out of date. We asked staff what they knew about the Friends and Family Test, and there was a mixed response. It is important that wards and departments are aware of feedback from the test so that they can develop and improve services.

Feedback from staff

The trust told us that it had a staff survey tool known as 'ChatBack'. The Chief Executive told us this data helps the executive team to measure staff satisfaction in a more detailed way than the national staff survey, and he feels that ChatBack gives him a useful platform to work from. The results for the 2013 survey were not available, but we looked at the results for 2012. The report to the Board showed that the majority of results that were compared with the previous year's results had declined. This included overall job satisfaction and belief that care of patients is a top priority. This equated to an 'amber' overall rating. There were different levels of awareness of ChatBack among staff. Managers and senior clinical staff were familiar with it, but staff at lower grades less so.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust's leadership team has been through a number of changes in recent years; notably the Chair was appointed in March 2013. The Chief Executive and the Chief Nurse have been in post since 2004 and 2005, respectively, bringing some stability to the leadership team.

The trust scored in the top performing 20% for 10 of the 28 indicators on the NHS staff survey, and generally staff across the organisation had a positive view of the trust's leadership team.

Our findings

Governance

The trust had recently undertaken a review of its governance structures. The conclusion of the review was that some committees needed to be re-aligned to ensure there was a better perspective on what was going on in the trust. Most new committees had only had one meeting, so it was too early to say what the impact of the new structure had been. The trust chair told us he felt the new structure would give the board a better link to patient experience.

We spoke to staff in the wards and departments about the governance arrangements at the trust. There was a mixed response. Some staff were very clear as to how the communication lines operated across the organisation and felt well informed, but others were unclear. This may have been because of the new structures, but it is important for a trust to ensure staff are clear on the lines of communication.

Accountability

The trust Board was relatively new in its current format, but the Chief Executive and Chairman had confidence that the board would develop positively. The Board's relationship with other key groups was also reported as good. The Chief Executive said the trust had an "excellent" consultant body that was highly valued, and the consultants told us relationships were good and that they felt supported. Most were aware who the trust Board members were. The trust had recently increased its divisional management structure to five divisional medical directors. These arrangements were also relatively new and untested.

The inspection found that a number of the directorates were well-led and that management roles were clearly defined. Theatres had developed a positive culture and demonstrated strong leadership. However, this approach was not evident at all levels. We found that some nursing staff on the wards either did not feel empowered or were not empowered to make key decisions that impacted on the patient experience, notably on the care of the elderly wards.

The trust told us that it had an open and transparent culture, that it welcomed reporting on incidents and acted swiftly to resolve issues. Nearly all staff we spoke to knew how to report incidents and were able to describe some form of feedback. We also found that in some areas the open and transparent approach had been translated by staff into a blame culture, which could hinder development.

Some of the wards we visited had no open display of information about the quality of care on the wards or in the department (for example, there was no indication of harm levels (falls, pressure ulcer rates etc) and there was limited knowledge amongst staff of their ward's performance figures). In some areas this was because there was no on-going assessment of quality. Visible displays of performance data helps to focus the minds of staff and lead to changes in behaviour, such as greater awareness of falls or pressure ulcers. This helps staff to take greater care of patients and reduce the incidence of these harms.

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The accident and emergency department (A&E) had a total of 33 trolleys. It includes nine major and seven minor cubicles, four resuscitation area trolleys and a further seven patients in the clinical decision unit (CDU). Two rapid assessment trolleys and five paediatric areas also make up part of the department. Last year the department saw in excess of 100,000 patients; it was designed to see 70,000. At our inspection, we were told that the department's new £2.5 million extension would open on 5 November 2013. This will provide an additional nine cubicle areas.

On the day of our visit, the department had between 35 and 45 patients at any one time. We were told that it was a quiet day, as until 3pm the department had seen 164 patients; on a busy day there could be up to 350 patients in a 24-hour period.

Summary of findings

Staff were caring and responsive to people's needs. Patients and relatives were positive about their care and spoke highly of the staff. Staff had a positive approach to providing care in an environment that was experiencing increasing demand, given that a neighbouring hospital's accident and emergency department operated restricted hours. This additional demand had impacted on the responsiveness of the department, but the trust had put in place plans to extend the department to cope with the extra pressure. Although we observed an emphasis on quality, we had some concerns regarding the leadership of the department and how it communicated key messages and lessons it had learned.

Accident and emergency

Are accident and emergency services safe?

Patients' views

Patients received safe care in A&E. They said they felt safe in the department. Some patients were being cared for in a rear corridor of the department. They said they felt safe, as a nurse was always present. Staff confirmed that a trained nurse and a support care worker were always assigned to this area when it was in use, and patients were monitored every half an hour to check their condition. We also heard that if a specific number of patients were in the corridor area, additional staff were allocated to care for these patients. The trust had therefore taken steps to minimise the risks for patients when the department is over capacity.

Staffing

There were sufficient numbers of staff on duty at any one time, and there was little use of bank and agency staff. Regular staff working extra shifts within the department covered gaps in the roster. This meant there was always a sufficient number of staff who were familiar with the department and the way it worked, ensuring consistency of care for patients.

Mental health patients

We were concerned about the safety of mental health patients. The department had a room for treating patients with mental health issues whose behaviour put staff or other patients at risk. The room was intended to keep the person safe while they waited for staff from the mental health trust to attend. To enter or exit the room, staff needed a pass that was issued by the Royal Wolverhampton NHS Trust, but mental health trust staff did not have one of these passes. So they could not get out of the room using their own pass. Similarly, patients were not able to exit the room either. This created potential problems regarding the deprivation of liberties for these patients. There was a panic strip in the room. Although this alerted people outside the room to the fact that help was required, we noted that one end of this strip had been damaged and bare wires were exposed. These had been repaired when we visited the department again a week later.

Staff told us that mental health teams from a neighbouring mental health trust could take some time to get to A&E. Staff had adopted an informal policy of placing patients in the main area of the department until staff arrived, dependant on the risk to the patient and to others. The trust could not tell us how often and for how long it used the room in question, as records are not maintained. This meant that patients using this room were not safe and potentially patients using the remainder of the unit were also put at risk.

Are accident and emergency services effective?

(for example, treatment is effective)

Environment

The A&E environment is small and not fit for purpose, the team are treating over 30% more patients than the department was designed for. The new extension will provide some additional capacity but the trust feels that this will not fully address the challenges of increasing demand.

There were plans in place to treat everyone who attended the hospital. The use of the rear corridor to admit patients into the unit and provide care was effective and staff managed risks well – even if using the corridor was not the ideal solution to increasing numbers of admissions.

Eye problems

A number of people told us that patients with eye problems were sent to the eye department from A&E, this journey was difficult, especially for patients with visual impairments. We reviewed the treatment of patients with eye problems. We found that the trust had recently introduced good systems so that most patients could now be treated in A&E without having to be sent to the eye department to access specialist eye care for treatment. This is an example of effective treatment for patients in the A&E department.

National targets

There is a national target to discharge or admit patients within four hours of arrival at A&E. Management data showed that the trust was meeting the target on most occasions. The target was achieved every week from week ending 5 May 2013 up to the week ending 1 September. This meant that patients were seen in a timely manner. However, the percentage of unplanned readmissions within seven days was consistently higher than the national average. We found that the clinical decisions unit admitted

patients from the emergency department for investigation and some patients were readmitted to the emergency department for further treatment. Staff told us that this was a regular occurrence and may have led to some of the readmissions highlighted. This meant that patients did not always receive appropriate care in a timely manner.

Are accident and emergency services caring?

Patient feedback

Patients felt involved in their care and well looked after. Staff felt that they were a close team who genuinely wanted to do their best for every patient. One member of staff said that the staff worked with their "hearts and minds" and treated everyone as an individual. Patients felt that staff were compassionate and that they included their relatives in discussions about their health needs when appropriate. Staff were respectful and treated patients with dignity. They closed curtains when interacting with patients and they asked relatives to leave when they needed to discuss intimate issues with patients.

Comfort round checklists

We noted that records included comfort round checklists. These ensured that every hour patients were asked about their comfort, toileting and dietary needs. Patients reported that they felt cared for when staff asked about these needs. We checked the records of five patients and found that this checklist had been completed in all cases. This shows that staff were undertaking this duty.

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

Responding to needs of patients

The trust was also responding well to the needs of patients in the department. For example, to respond to the needs of children it had created a specific waiting room and treatment area. This area was well signposted, and patients reported that staff were good at keeping them informed of what was happening. Patients and parents valued the work of the paediatric staff.

Learning difficulties

At our listening event, people spoke to us about delays in treating family members with learning difficulties and autism. When we followed this up with staff, they told us that there were nurses who were specially trained in this area of care in the department and they recognised that the department could do more. We were told that staff now prioritised these patients to reduce any distress caused by waiting.

Equipment

The trust responded appropriately where equipment was required. The department had recently been inspected by the Deanery, who had recommended that an extra resuscitation trolley be purchased for two areas of the unit. We saw that these were in place within a week of the Deanery's visit. We also saw an electronic drug dispensing system in use in the department. This meant that the dispensing of drugs was made safer and that records were kept for auditing purposes.

Consultants responding to requests

We had concerns about consultants responding to requests for support in A&E. Junior medical staff told us that consultants sometimes refused to come to the department to help when there were a large number of patients. We saw numerous incident reports relating to this issue, but no action had been taken. This meant that the department was not always responsive to the needs of patients attending for treatment.

Are accident and emergency services well-led?

Managing staff

Staff felt well supported in their roles. All medical and nursing staff said they felt that they were well supervised, both when they first started work in the department and during their working career. Junior nursing staff felt well supported by the departments' sisters, and they felt they could raise issues safely. The junior doctors said that they felt well supported by the senior staff and that they discussed any decisions they made with senior staff. This meant that patients were cared for by staff who were supported and felt valued.

Learning from serious incidents

We were concerned about the way serious incidents were managed in the department. Staff told us that not all

incidents were reported, due to time constraints. We asked senior staff how they monitor the incidents in the department, and they could not show us how they use the data on the trust's internal system. We asked staff about the last serious incident and what if any lessons that were learnt from this. No member of staff we spoke to was able to respond to this query. We found out that all trust staff received an email about any lessons to be learnt from incidents. But we were not able to confirm that staff had read these emails. This meant that there was a possibility that the service would not be improved by learning from adverse events and incidents.

Visibility of senior leadership

We were concerned about the visibility of the senior leadership at directorate level. We did not see any senior management in the department during our inspection. Nor did staff refer to them during our discussions. Staff in A&E said that they felt isolated from the rest of the hospital and that they were unaware of issues in other areas. This meant that the department was at risk of not sharing learning with other parts of the organisation and following trust strategies.

Skills of new staff

There were concerns about the skills and experience of some new members of staff. The department had recently employed a number of new staff, as the trust was about to open a further eight beds. Some staff felt that the skills and experiences of these new members of staff were not always what senior staff would have wanted. An example of this was the appointment of senior doctors without advanced life support skills. This meant that patient's safety could be compromised by the skills and experience of some staff at the trust.

Auditing the quality of care

We asked staff about the system of auditing the quality of care. Most staff said that patient feedback (written or verbal) was a large part of their monitoring system. We saw evidence of checklists to audit support systems, for example to check the resuscitation trolley and monitor of the temperatures of the drug fridge. With this checklist approach, it was not always easy to see whether any action was taken to address deficits. On questioning staff, we were unable to work out if anybody analysed data from these audits. This meant that trends could not be identified and corrective action put in place. Therefore there could be no improvement to services as a result of the audits.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Our inspection of medical care services included acute medical units, general medical wards and care of the elderly. We spoke to many people over the course of a two-day inspection and used information from comment cards completed in the waiting area.

We inspected four medical wards and the discharge lounge.

Summary of findings

The hospital must take action to improve the responsiveness of care for older patients. We were concerned that elderly care and dementia wards were not sufficiently staffed, particularly at night, where there was one registered nurse for every ten patients. We felt this was impacting the safety and effectiveness of care. The trust must also ensure its dementia care bundle is implemented consistently on every ward.

The trust had systems to manage the safety of patients on the medical wards. Staff knew how to report serious incidents and told us that the trust learned lessons from any feedback provided. There were systems to monitor the needs of patients, and there was evidence that the trust was responding to these needs. The trust routinely reviewed the quality of care, and we saw evidence that it responded to the findings of these reviews.

Ward staff told us about specific changes they had made to make services more effective. They displayed a caring and sensitive approach to patients and relatives, but we were concerned about two isolated incidents where staff failed to respond to call bells in a timely manner.

There were specific examples of the trust developing systems and services to ensure that it met people's needs. For example, it has developed a dementia ward. However, for patients not on this ward the trust's dementia care bundle was not fully implemented and we were concerned about the levels of staffing on some of the elderly care wards. Protected meal times and the system for helping patients to eat and drink was not consistently applied across the hospital.

Medical care (including older people's care)

Are medical care services safe?

Getting clinical advice and support

Nursing staff told us they had good access to junior doctors and consultants and this meant that they had prompt access to clinical decision-making. They also said they had access to advice outside normal working hours and at weekends. For example, on the acute stroke ward nursing and medical staff said that multi-disciplinary team meetings took place seven days a week. On a respiratory ward a patient told us they often saw a doctor and saw their consultant "every few days". This meant that clinical decisions about treatment could be made when they were needed, and this helped the service to meet patients' needs promptly.

Staffing

Staff on some of the medical wards felt that staffing level levels were sufficient to allow them to provide safe care to patients. The rotas we looked at on some wards confirmed that staffing levels with the numbers expected to be on duty. Staff were busy on the wards we inspected, but they made time to provide care to patients.

We were concerned that the elderly care and dementia wards were not sufficiently resourced, especially in the evening and at night. There was one registered nurse for every ten patients. The wards were very busy, it was a challenging environment and staff were only able to deliver the basic care requirements.

Responding to risk

We found that appropriate assessments were in place to manage risks to patient safety such as venous thromboembolism, falls, malnutrition and the occurrence of pressure sores. Staff told us that when patients arrived at their ward from other areas of the hospital they were reassessed for these risks. Patient records confirmed this. Where patients were at high risk, staff had taken appropriate measures to stop the risks occurring. This meant that patients could be assured their safety was being assessed and managed.

Senior nursing staff in charge of the wards told us they carried out a daily check of every patient who was at risk of developing sore skin. Records showed that these skin checks had been recorded and that they were also carried out on patients who wore specialised stockings to prevent thrombosis. This meant that staff would be able to identify if these patients had developed sore skin and take appropriate action.

Using checklists

Staff used checklists to ensure that safety procedures were followed. We examined the World Health Organisation checklists for chest drains which had been completed on a respiratory ward. We saw that the checklists had been audited by the nurse in charge of the ward to make sure they had been completed correctly. We saw examples of where this audit process had found gaps. The nurse in charge was able to explain how they had followed up on these gaps with individual members of staff. This showed that nurses were effectively managing the care of patients on this ward.

Safety briefings

Staff said that they took part in a safety briefing every morning to identify which patients were particularly unwell, likely to be confused, likely to become aggressive and at risk of falls. This meant that staff were aware of patients' changing needs and could provide care that met those needs.

Managing patient observations electronically

Some wards used an electronic system (called 'VitalPAC') to record patient observations. The system also identified how often staff should observe patients, depending on the level of risk identified during their risk assessments. Staff we spoke with understood how to use the system and were confident it would help them to know quickly if a patient's condition had deteriorated. However, this was not the case on the elderly care wards. For example, on one occasion we were concerned about a patient's observations and nursing staff were not able to show us what medical intervention there had been.

In wards where the electronic system was not in use, we saw that staff also carried out regular ward rounds which checked whether patients were in pain. We saw that these checks were recorded. This meant that staff wound be able to give appropriate medication or pain relief promptly if it was needed.

Discharging patients

Some of the wards we visited had discharge support coordinators. Nurses spoke positively about these co-ordinators, saying that their presence helped them to do

their jobs more effectively as well as helping the discharge process to run more smoothly. We also spoke with nursing staff based in the discharge lounge. They told us they also help staff on the wards to prepare patients for discharge, for example by helping them to wash and dress. These arrangements help to ensure that staff discharge patients effectively from the wards.

In the discharge lounge, staff told us they felt authorised and able to make decisions about whether to discharge a patient if there was doubt about their safety. They gave us a recent example of when a patient had been sent to be discharged from their ward in the evening. They said they had felt that it would be unsafe to discharge the patient at that time of day. They told us they had arranged for the patient to remain in a bed in the discharge lounge until the following day and that they had arranged for a member of staff to look after them.

In the discharge lounge we saw that a system was in place to double check the accuracy of the medicine a patient was given to take home. This reduced the risk that patients would be discharged with the wrong or insufficient medication to meet their needs.

Are medical care services effective?
(for example, treatment is effective)

Supporting patients with dementia

On elderly care wards, the trust's specific 'dementia care bundle' was not always fully in place. The trust developed this 'bundle' to help the ward staff give the best care for people with dementia, taking into consideration their safety and personal preferences. In one case, not only was the dementia care bundle not fully completed, but nursing staff had also overlooked the patient's wound care and pain control. On the same ward, nursing staff had not considered or reviewed another patient's nutritional needs. The dementia care specialist nurse and their staff team told us that the dementia care bundle had been rolled out to the wards. But the evidence we saw suggested that this had not been done fully, which meant that staff were not meeting patients' needs. We also saw instances of patients' dignity not being maintained on the dementia ward. One patient was sat on the ward in a state of partial undress and in full view of other people.

Monitoring quality

There were systems in place to monitor quality of care on the wards. Senior nursing staff told us they carried out regular quality rounds that included a selection of 10 patients and included checks on hygiene and whether the patient had a call bell within reach. They told us they reported the results of these rounds to their matron. Junior staff on these wards confirmed that quality rounds took place.

Improving effectiveness

The nurse in change of one ward described how the ward had changed the way it worked over the previous year to be more effective: senior staff had identified and addressed training gaps through appraisal, supervision and training. Junior staff confirmed this and said that they now felt more involved in clinical care as a result of the training. They now actively encouraged patients to remain out of bed and do as much for themselves as possible to help with their rehabilitation. Patients on this ward said they were happy with their care and treatment, and we saw figures which showed that the average length of stay for patients on this ward had been significantly reduced.

Meals

We observed meal times on the elderly care ward The trust had a protected mealtimes policy, which meant that all non-urgent clinical tasks stopped for a period of time so that patients could eat their meals without rushing. . Staff served the patient's chosen meal on a tray to them at their bedside. The trust had a number of systems operating that alerted staff to the patients on the wards who required assistance with eating and drinking. This included the "SafeHands" electronic system and safety briefings on the wards. We saw that this was not always an effective way to support people. We observed many examples where patients did not get the help they needed. One person's meal was left uncovered in the ward area while staff attended to them. This was brought to the attention of staff, and the meal was replaced. One person's meal was removed without the person eating anything.

Delays

We found examples of ineffective care on the wards. Two patients described how they had waited for extended periods for care and treatment they had been promised. They felt that these delays had happened because there were insufficient numbers of staff on duty. Staff confirmed

that on that shift they were operating with a smaller number of healthcare assistants than was usual. Although this may be an isolated incident, staff were not meeting the needs of these patients effectively.

Are medical care services caring?

Interactions between staff and patients

We found staff to be compassionate and caring. We saw a number of warm interactions between staff and patients, particularly on the acute stroke ward.

Drinks rounds

Staff said that there were regular drinks rounds, and patients confirmed this and said that they had had enough to drink. We saw that staff routinely checked if patients were thirsty and that volunteers also came in to give patients drinks. Staff put refreshments within patients' reach.

Patient feedback

Patients gave positive feedback about the care they received. One patient told us, "I'm happy with the care. The nurses are good, the doctors are okay and the consultants are good."

Call bells

Staff made sure patients had call bells within their reach so they could ask for help if they needed it. We noted that staff replaced call bells if they had slipped out of a patient's reach. On most wards, call bells were answered promptly. However, we saw and heard of isolated incidents where patients had to wait for staff to answer call bells. For example, on a respiratory ward one patient told us they had gone to fetch a nurse after the patient in the next bed had waited 10 minutes after pressing their call bell for a bedpan. During our inspection on this ward, we heard an alarm bell ringing in a bathroom. We checked a display at the nurses' station which indicated the alarm had been ringing for over 20 minutes. During this time there were staff present at the nurses' station. We raised this matter with the senior nurse, who made sure the patient was safe. Nursing staff on this ward told us they were expected to answer any call or alarm bells immediately.

Discharge lounge

Nursing and care staff in the discharge lounge told us they would not interrupt protected ward mealtimes for a patient who was about to be discharged. However, one patient in the discharge lounge told us they had been removed from their ward before they had finished eating their lunch. The patient said they had been told this was because they were about to be discharged. They told us they had since been waiting in the discharge lounge for two hours.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Access to appropriate services

Patients in a number of areas said that they had been able to access appropriate services which had met their needs. For example, a patient on a respiratory ward told us how they had been admitted to the ward within two hours of arriving at the Accident and Emergency (A&E) department. A patient on the acute stroke ward also told us they had received prompt access to treatment and services.

We witnessed an example of how services were accessible and responsive in practice. Staff we spoke with on the cardiology ward told us that patients were often admitted directly from the ambulance or air ambulance rather than passing through the emergency department. Staff had a dedicated telephone which could be used by ambulance crews to inform them in advance about the condition of the patient they brought in, so that the ward could ensure that appropriate staff and equipment were available. During our inspection of this ward we saw that one seriously ill patient was admitted in this way.

Dementia ward

The trust had set up a ward specialising in care for patients with dementia. Staff said that the ward had been set up as a 'centre of excellence' so that the trust could be more responsive to the needs of patients with dementia. We heard that there was an outreach team to identify patients admitted via A&E whose needs would be best met on this ward. Staff were positive about this ward and told us it helped to reduce the number of times a patient with dementia would be moved during their hospital stay. Nurses told us they could access specialist advice about patients with dementia from the outreach team. This meant that staff were better supported to meet the needs of patients who had an acute medical condition and dementia.

Medical care (including older people's care)

Are medical care services well-led?

Staff were positive about training opportunities. They told us they received regular supervision and appraisal and that they were released by their managers to attend the training they needed. Staff on the wards were able to give us examples of recent training they had been able to attend. This meant that these staff had received training to help them meet the needs of patients.

Visibility

The majority of staff we spoke with said that senior management of the trust were visible and that they regularly saw members of the senior management team around the hospital. We found that some of the more junior staff on the wards did not know the names of senior staff (for example the Chief Executive and Director of Nursing). Some of the patients we spoke with on the wards told us they did not feel that trust managers were visible enough.

Feedback

Information and feedback about the trust's performance did not always filter down to junior members of staff. For example on one ward we found that a consultant had an in-depth understanding of the trust's recent performance in preventing venous thromboembolism. However, a junior doctor on the same ward was not aware of issues that the trust faced in this area. The trust did not routinely display information on its performance. Information we found on the wall in one ward was six months out of date.

Senior trust staff told us that staff could also raise concerns or provide feedback using a staff survey tool called 'ChatBack.' We found that more senior staff were aware of this survey tool and had used it. They said ward managers received feedback by email and that it was then their responsibility to give the feedback to junior staff. However, we found limited awareness of ChatBack among more junior staff. A number of healthcare assistants and junior nursing staff told us they had not heard of the system. This showed us that the Board was not fully aware of how effective its feedback mechanism was.

Incident reporting

We spoke with nursing staff of different grades about systems for reporting and learning from patient safety incidents. They were able to describe the process they would follow in the event of a serious incident and were able to give examples of incidents they had reported, for example falls and the occurrence of pressure sores. They told us that senior ward staff received feedback on these incidents at regular governance meetings. The senior staff would then pass the feedback to them, either informally or during staff meetings. This shows that systems to report and learn from incidents were working effectively in this area.

Staff at all levels of the organisation knew how to escalate any concerns they had about patient safety. They told us they were aware of procedures for safeguarding (protecting patients from abuse) and whistle blowing (reporting wrong doing in the organisation) and that they had received relevant training. They told us they would feel comfortable raising concerns with their managers, that they felt their managers would take them seriously and that they were confident that management would take appropriate action.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

We visited day wards and overnight stay wards during this inspection. The day wards were part of the critical care directorate and the overnight wards were part of the surgical directorate.

Wards were divided into specialties such as general surgery, trauma and orthopaedics, head and neck, urology, cardiac and gynaecology. Although some of the wards were on a different floor from the appropriate theatre suite, there was no dedicated theatre lift.

We were able to speak to patients on all of the wards we visited. We also spoke to ward staff and the nurse in charge or a senior nurse for each area.

Summary of findings

Patients and staff said that wards were well staffed by day and patients felt well cared for. However, they felt they did not have enough staff at night. Patients told us they had to wait for pain relief sometimes as a result. Staff on some wards said that staffing levels at night did not enable them to run their wards safely. The trust were aware of this issue and had taken steps to address it.

In theatres we noted the efforts made by the leadership team to address the issue of Never Events and develop an open safety culture. There were systems in place to ensure services were safe and we observed a positive culture in theatres regarding the reporting of incidents. There were some initiatives in place to make treatment effective. For example, there were specialist doctors for people who had dementia and had been admitted with bone fractures.

Staff on the ward told us that they were well-led and that senior management within the hospital were visible and wanted to know about patients' care.

Surgery

Are surgery services safe?

Staffing levels

During the day, we saw that wards had sufficient staff to deliver safe care to patients. We had some concerns about the number of staff available at night on the inpatient surgical wards. Both inpatients and people at the listening event told us that they had to wait for pain relief and other assistance at night. One person at the listening event told us, "You can ring the bell and nothing happens. Another person told us, "I had to ring the bell for the person opposite me, it took ages for anyone to come". An inpatient told us, "You have to take your turn at night and wait." We spoke to nurses in charge of the surgical wards who told us that they felt they did not have sufficient staff on duty at night to meet patients' needs safely. The trust told us they were aware of these issue and had submitted a bid for further funding from local commissioners to address some of these shortfalls. Patients' nutritional needs were met. The trust had sufficient systems in place to prevent patients becoming dehydrated or malnourished if their surgery was postponed or cancelled (patients who are expected to go for surgery are not allowed to eat or drink for several hours before surgery). There was an escalation policy for management of patients whose surgery could be cancelled on the day of surgery, and theatres and the surgical wards worked together to prevent cancellation wherever possible. On the trauma ward, staff gave patients a fortified energy drink before they stopped eating and drinking.

Safety briefings

Staff confirmed that the trust had safety briefings three times a day throughout the hospital. There was a dedicated section of each handover for focusing on safety and actions that needed to be taken or that had been taken that day.

Infection control

The trust had appropriate infection control systems, but we noticed that they were not strictly observed in all areas. For example, we saw staff opening pedal operated bins by hand. Staff who had not used the bin properly did not always clean their hands afterwards. This created a risk of cross-contamination.

VitalPAC system

The wards we visited used the hospital's electronic VitalPAC system, which recorded patient observations, informed staff when specific observations were due and set off an alert when an observation was overdue. Staff we spoke with understood how to use the system and were confident it would help them to know quickly if a patient's condition had deteriorated. We saw that this system monitored patients at risk of venous thromboembolism (VTE). The hospital had adopted this system to improve patient safety. Consultants told us they felt this system had reduced the incidence of VTE post-surgery and that there was a downward trend in VTE incidence. However, data we collected before our visit showed us that recently the trust's rates had been increasing.

Sharing information from never events

Theatres had shared information about never events (events that are so serious they should never happen) with the surgical wards, and staff knew about these events. So there was an open culture for safety, which meant that people would be more likely to report events and continuously improve the patient safety culture.

Skin damage from pressure

People who have had surgery could be at risk of developing skin damage from pressure. Careful observation of patients' skin condition reduces the risk of skin damage. We saw that the nurse in charge of one of the surgical wards checked every patient's skin condition and recorded the results daily. Suitable pressure-relieving equipment was in use for people who required it on the wards we visited.

Are surgery services effective?
(for example, treatment is effective)

Mortality indicators

Some of the data we collected before our visit showed that the hospital's mortality indicators were within the expected range. This was the case for cardiac surgery, general surgery, oral surgery, trauma and orthopaedics, thoracic surgery and plastic surgery. This means that that surgery was effective for patients at the hospital.

VitalPAC system

The use of the VitalPAC system was effective in the monitoring and management of patient observations within the wards we visited. We saw that staff used the system to check which patients needed observations. When a patient's observations reached a critical point, the team responded to ensure that the patient received the appropriate level of care.

Surgery

Falls data
Services had effective systems for auditing falls and action that had been taken to reduce risk or recurrence. The trust had remained below the national average for falls over the previous 12 months. However, although we saw data for 2012 on some of the wards, we saw no data for 2013.

Discharge lounge
Some patients told us that the discharge lounge was not an effective or pleasant experience. One patient told us, "I had a long and uncomfortable time waiting to be allowed home. They told me I only had to wait in the discharge lounge for a few minutes whilst my going home medication was fetched." Patients said that the discharge lounge procedure was ineffective.

Environment
The surgical wards and theatre suite were on different floors of the hospital. There was no dedicated lift for patients undergoing surgery. We were told that if the general lift was in use, members of the public were asked to leave it if staff were about to take a patient to or from theatres. This could pose a risk of infection as well as impacting on a patient's dignity. We asked if the trust reviewed this issue, and staff told us that they were not aware of any systems that measured the effectiveness of the current system.

Are surgery services caring?

We saw, and patients told us, that staff treated patients with kindness and compassion. Patients also told us that they were pleased with the care they had received and that they were happy with the way staff had treated them, even though wards became noisy and chaotic at night.

Patients and staff told us that some wards were very busy. We observed that some wards had a very fast turnaround of patients, and patients told us that they felt that some things were rushed.

Physiotherapy
Patients who required physiotherapy after surgery told us that the physiotherapist always checked that they were comfortable before beginning their therapy. Patient records revealed that patients received suitable pain relief up to 30 minutes before physiotherapy. Staff on the ward confirmed that physiotherapists asked if patients needed pain relief before having therapy. This meant staff were meeting patients' needs.

Patient transfer
The hospital had a patient transfer policy which set out the level of support a patient would be given when they had to move to other departments within the hospital. However, on two separate occasions we observed patients on beds being moved along the main hospital corridor without suitable support. One of these patients was not escorted by a member of nursing or care staff. We asked ward staff about this, and they told us that only patients who were well enough to be moved in wheelchairs would be unescorted by nursing or care staff. This meant that patients may be at risk of unsafe care.

Are surgery services responsive to people's needs?
(for example, to feedback?)

The orthopaedic ward had responded to the needs of its patients by dedicating 22 of its beds to planned orthopaedic procedures. This was in response to the problem of people who were having orthopaedic procedures sometimes being placed on other wards.

Introduction of initiatives
The trust had introduced initiatives to make sure people with two or more conditions get help from specialist medical staff. For example, there was an initiative to ensure that a specialist doctor treated elderly people with dementia and fractured bones.

Dementia patients
Staff on the trauma wards knew about the All About Me best practice guide for people with dementia. The dementia care pathway was also based on this guide. This meant that the ward could respond appropriately to the needs of patients who had dementia and broken bones.

Welfare needs
Patients on several of the wards reported problems with the bedside radio or television they had paid for. They said they had told staff there was a problem, but there was no one available to sort the problem out. This meant the trust was not responding to people's welfare needs on the ward.

Surgery

ChatBack survey

Staff said that the hospital had a 'ChatBack' staff survey tool that allowed them to report their concerns or submit questions. However, only the nursing staff we spoke to knew about this system or used it. Healthcare assistants did not know what ChatBack was or how the survey worked. This meant that the trust was not getting feedback from all levels of the organisation.

Are surgery services well-led?

Our observations showed that surgical wards were well-led.

The nurse in charge of the wards and the senior nurse knew about all of their patients. They told us about how staff monitored patients and explained the actions nurses took to monitor and prevent skin damage from pressure.

Communication

Medical staff said that nursing staff were able to tell them where to find patients who had been moved to other wards. This meant leadership had in place processes to encourage good communication amongst staff making decisions about which wards patients should be on.

Daily audit of care records

We saw that the ward sisters carried out a daily audit of care records to ensure that staff were meeting the needs of patients effectively, and to determine which patients may require additional support.

Surgical pathway

On the day wards we saw that good leadership ensured that the patient had a seamless journey through their surgical pathway (the 'journey' through different surgical services and treatment).

Support from seniors

Staff we spoke to on the surgical and day wards told us that they felt well supported and that their wards were well-led. Senior staff on the wards told us that matrons were visible and supportive. We were shown a diagram of the directorate structure: a clinical director, senior matron and directorate manager working as a triangular management structure to support each directorate.

Minimising risk of never events

The leadership team in theatres had taken a number of steps to minimise the likelihood of further never events. It had developed a defined safety culture in theatres, and this was evident in the behaviour of the staff. World Health Organisation checklists had been implemented in all theatres, and these were now an integral part of theatre practice.

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

This built-for-purpose integrated critical care unit (ICCU) had 28 beds open at the time of our inspection. Service staff told us that they would open a further two beds in the near future.

The unit linked at one end to the cardiothoracic theatre suite and at the other end to the cardiac ward. This meant that rapid transfer and support was readily available for patients who required cardiac intervention.

There were procedures in place to transfer patients to the ICCU from other departments within the hospital. This included one of the transfer team wearing a brightly coloured backpack which contained the emergency equipment which might be required during the transfer process.

The ICCU provided intensive care to cardiac and general intensive care patients. The unit offered its cardiac advanced life support (CALS) course to other providers twice a year. The unit practiced CALS once a month as part of its safety and effectiveness culture.

Summary of findings

We found that the intensive care and critical care unit was a safe and effective service. It was responsive to the needs of its patients and had caring staff. We found that the unit was well-led and that communication was effective across the multidisciplinary teams that worked within it.

Intensive/critical care

Are intensive/critical services safe?

We saw that the unit had a range of systems and procedures to ensure the safety of its patients. For example, it had checklists for procedures and safety handovers. ICCU used the electronic VitalPAC system, which allows staff to record patient observations electronically and alerts them when observations are due or late. Staff we spoke with understood how to use the system and were confident it would help them to know quickly if a patient's condition had deteriorated. We also saw a system called 'SafeHands', which measures safety and is useful for managing infection control. It also enables staff to call for assistance from other staff if a patient needs more support. The sister in charge of the unit demonstrated the SafeHands alert, and a medical member of staff arrived within a few seconds. This showed that the system was effective in helping staff provide safe care at the trust.

Staff told us how the unit planned for transfers of patients into and out of the unit. The unit had developed clear procedures to support the patient journey, and this included the use of an ambulance for some transfers across the hospital site. A member of the qualified transfer team wore a high-visibility backpack, which contained emergency equipment which might be required during the transfer.

We observed nursing staff politely and appropriately challenging medical staff who had moved between areas and not removed a mask. We saw that all of the staff on the unit cleaned their hands after every patient contact. This meant that the unit took appropriate steps to control and reduce the risk of infection.

Are intensive/critical services effective? (for example, treatment is effective)

The senior matron and senior nurse on the unit audited its systems (including systems for infection control) to ensure that they were effective. We saw that medical staff were part of the training team, and this ensured that up-to-date practices were shared with the entire multi-disciplinary team. The whole team would therefore be able to respond to an emergency situation effectively.

The unit had planned to increase its bed capacity so that all staff were trained and supported appropriately before the unit expanded. This meant that effective care could be given to patients within the ICCU.

The unit was accessible from both the cardiac unit and the cardio thoracic theatres. The access from the cardiac unit provided rapid and effective support to patients who required intensive intervention.

This service is effectively staffed by consultants and nurses 24 hours a day seven days a week. The hospital is therefore able to offer an effective critical care response to patients who require it at any time.

Due to the changing health needs of the patients treated on the unit, the unit was technology rich. There were suitable systems in place to ensure that equipment was ready for use and functioning effectively at all times. Staff carried out suitable checks and kept appropriate records, and everybody we spoke with knew how to report any problems with equipment.

Are intensive/critical services caring?

We found that staff were caring and compassionate on the unit, and we saw staff providing care in a sensitive and dignified manner.

Patients' families told us that the care their loved ones had received was wonderful, excellent or very good. Relatives we spoke with told us that they felt supported by the staff while their loved ones were in ICCU.

We observed staff informing relatives about patient's progress, they also confirmed that treatment and care was explained and they had been given an opportunity to ask questions. Staff provided relatives with information about what to expect on the unit, and relatives confirmed that they were well prepared for this environment when they visited.

Intensive/critical care

Are intensive/critical services responsive to people's needs?
(for example, to feedback?)

We saw that the unit was designed to support patients' changing health needs. Staff had rapid access to both theatres and the cardiac ward, so they were able to respond to patients' needs as quickly as possible.

The unit was well equipped and staffed so that people's needs were met without any delay.

Medical staff provided a service seven days a week. As nursing staff had already been providing seven-day-a-week care, involving the medical staff in the same pattern of work improved the teams' responsiveness to their patients' needs.

People said that parking was a problem for this unit and that it was a long way to the other car parks. We saw that the hospital had started the development of a new car park. This meant that it had acknowledged and was responding to the parking problem for this unit.

Are intensive/critical services well-led?

Our observations showed that ICCU was well-led.

The senior nurse on the unit was knowledgeable about the speciality and showed us the main station where information was shared. We saw that a large electronic board was updated every time a new patient observation was recorded. The senior nurse explained how patients were risk assessed and how staff were allocated to support these patients. This meant that the staff were properly supported to care for the patients they were allocated.

Staff confirmed that they received suitable training to carry out their roles and that the training took place in protected time (time that was dedicated to training).

Senior management were visible to the unit, and staff told us that members of the senior management team visited the unit frequently.

Staff told us that they felt included and part of the team and that the unit management were accessible. Staff were able to ask about anything and to discuss any concerns they might have.

We were shown a directorate structure: a clinical director, senior matron and directorate manager worked in a triangular management structure to support each directorate.

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust had a separate maternity unit based at the hospital site. This included a 36-bedded maternity ward for antenatal and postnatal patients. The trust refurbished the ward at the beginning of 2013 and it consisted of a mixture of four-bedded bays and single rooms. A four-bedded high dependency area was located centrally within the ward, which also had a baby nursery facility.

The maternity triage unit and delivery suite were located next to each other. The delivery suite had eight delivery rooms. Separate facilities were available for bereaved patients. There were two maternity theatres, and these were located within the delivery suite.

A midwife-led unit was opened at the hospital in October 2012. This facility was intended for patients with 'low risk' pregnancies and consists of five birthing suites with state-of-the-art birthing equipment. The unit had been closed, temporarily, since the end of August 2013, due to staff shortages across the maternity unit.

The trust held antenatal clinics on the ground floor of the maternity unit. A day assessment unit was part of this facility.

Summary of findings

The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence, this issue has been included on the trust risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas.

There were systems in place to ensure patient safety. This included the management of staffing levels and skill mix to ensure that sufficient staffing was available to meet patients' care and treatment needs. However, people raised concerns that a shortage of staff had meant that not all patients had received regular postnatal home visits from midwives after being discharged.

Maternity and family planning

Are maternity and family planning services safe?

Staffing

The trust told us that it currently had a shortage of midwives, within the hospital and the local community. We heard further evidence to confirm this during our discussions with patients and the staff team. Some people told us that this was of particular concern during night hours at the hospital and while receiving care at home. The trust explained that the shortage was due to a number of reasons, such as staff maternity leave and long-term sickness. In response to the problem, it had added the issue to its risk register and had taken actions to alleviate it. However, there were still concerns about delays within the maternity triage unit and the availability of midwives to undertake home visits.

The trust had plans to recruit additional midwives, and it had recently appointed several additional healthcare assistants. Several midwives had also been appointed, and pre-recruitment checks were being undertaken at the time of our inspection. This meant that the trust was checking that they were suitable to work within the maternity service. Further staff interviews were planned.

The trust had introduced a 'bank' of midwifery staff (staff who work to fill any gaps in the rota). This meant that it could call upon these staff in times of staff shortages or unexpected demand. The trust told us that staff on the bank rota had received inductions for the areas of the hospital where they worked. This meant that staffing levels were maintained by staff that had been assessed as being competent to work in the relevant area.

Dealing with high demand

The trust told us that there had recently been increased demand throughout the maternity service, due to a rise in the actual numbers of patients and patients with complex care needs. It had arrangements to deal with patient numbers reaching full capacity and with staff shortages. For example, when there were not enough staff to provide safe care and treatment written guidelines provided staff with instructions about the order of actions to take. Senior staff had a good understanding of this escalation process, and we noted that it was reviewed daily. This meant that the trust had prioritised patient safety, assessed potential risks and taken action so that patients could get the care and treatment they needed at any time

Managing risk

There were robust systems in place to ensure that the trust dealt with any incidents that occurred at the hospital in an appropriate manner. This included policies, procedures and monitoring of incidents that had occurred. Staff told us that they knew how to report an incident if one took place. The trust investigated serious incidents to identify their causes. The trust had appointed a specialist midwife for risk management, and it held monthly risk management meetings.

We noted that staff regularly checked the emergency equipment, so that it was ready for the next patient's use.

We noted that staff completed 'safety checklists' for patients who underwent obstetric surgical interventions. The trust monitored whether the checklists were being completed correctly. In August 2013 it realised that not all of the checklists had been completed fully. It carried out an investigation to find out why this had happened, and it took action to address the issues identified.

Are maternity and family planning services effective?

(for example, treatment is effective)

Patient satisfaction

We spoke with patients who were attending antenatal outpatient appointments. Most patients told us that they were satisfied with the antenatal service they received. One patient told us, "I see the same midwife every time that I attend. I haven't got any complaints."

Most patients were also happy with the level of care in the maternity triage unit. One patient told us, "I have been seen pretty quickly." However, several patients told us that they had concerns about the length of time taken for their care needs to be assessed on arrival to this unit. They told us that this had resulted to delays in treatment. A patient told us, "I discharged myself in the end, because I didn't want to wait."

Maternity and family planning

Most patients told us that they were satisfied with the care and treatment they had received on the ward. Patients told us: "I have not had any problems, I have had adequate pain relief" and "There has been enough staff, although they change a lot".

Handovers

When staff changed shifts, the handover from one staff team to the next included both verbal and written information. This ensured that patients had good continuity of care and were cared for by staff who had up-to-date information about them. However, a midwife that worked on the maternity ward told us that handovers were sometimes ineffective. due to increases in demand and staff shortages. We observed handover taking place on one ward, during our inspection and saw that it was robust and covered all the patients on the ward

Closure of the midwife-led unit

The temporary closure of the midwife-led unit had meant that patients' choice about where to give birth had been reduced. The midwife-led unit was intended to support patients who had been assessed as having a low risk of complications during labour and delivery. At the time of the inspection, patients had the choice of giving birth on the delivery ward or at home, although women could still choose a midwifery led birth on the delivery suite. The trust had used the community midwife team to give patients information about this. The trust told us that the closure of the midwife-led unit had not had a negative impact on patients who had opted for home births, but we do not have any evidence to confirm this.

Are maternity and family planning services caring?

Staff provided care and treatment in a caring and sensitive manner. There were good interactions between staff, patients and their families. A patient on the maternity ward told us, "Staff have been friendly and helpful."

Information for patients

When patients first started to use the service, they were given written information about the types of services and facilities provided. This information was available in a range of languages so that more people could access the information. Information of interest to patients and their families was also on display throughout the hospital. This included details of visiting times, parent education and details of other organisations that could provide support to patients and their families. However, we noted that in the antenatal clinic there was only limited information for people who didn't have English as a first language.

Family-centred care

Care within the maternity service was family-centred. Patients told us that they were actively involved in their baby's care and that staff provided support that enabled them to do this. Nursery nurses were available and spent time educating new parents so that they would have the skills and confidence to care for their baby on discharge. Specialist breastfeeding staff were also available to support new mothers.

Most patients told us that staff explained the care and treatment provided and that they took the time to answer any questions they had. Most patients told us that there was good communication between them and staff team. Documented discussions between medical, midwifery staff and patients gave further evidence of this. A patient told us, "The maternity team have been upfront and honest. They have explained everything well."

Respect and dignity

The trust had recently appointed a 'ward hostess' for the delivery suite. This person was available to support patients, for example during the serving of meals. Plans were in place to extend this role to the maternity ward.

There were arrangements to ensure patients' privacy. Private facilities were available for patients' use throughout the wards and departments. This included quiet rooms and breastfeeding rooms. Privacy curtains were used at patient's bedsides. There were designated bays for antenatal and postnatal treatment in patients within the ward. This showed that that the trust had given consideration to providing compassionate care. However, while we were in the antenatal clinic, we saw that staff had left patients' health notes unattended in a public area rather than store them securely.

Comprehensive arrangements were in place to support bereaved families. The trust had appointed a designated staff team to take the lead in this area. The team had received enhanced training in order to support families in a competent and sensitive manner.

Maternity and family planning

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Maternity services

The trust had systems to ensure that patients had good access to maternity services. After receiving antenatal care during pregnancy, most patients accessed the maternity inpatient service through the maternity triage unit. There were medical and midwifery staff on this unit, so that an assessment of patients care and treatment could be undertaken. The maternity triage unit was also used for 'high risk' inductions of labour. All telephone calls from patients were handled centrally within the unit. A healthcare assistant took patient details, who then shared the information with a midwife. This was so that decisions could be made about patients' care pathways. This demonstrated that the service responded to patients in a timely manner and in a way that met their needs.

Care pathways

The trust had made arrangements to provide appropriate care pathways to respond to patients who required planned admission. For example, staff carried out pre-operative checks in a separate facility on the maternity ward and there were two maternity theatres located in the delivery suite. Senior staff told us that there were two maternity theatre teams between the hours of 9am and 1pm. This meant that an elective theatre list for planned caesarean sections could run alongside emergency surgery. The maternity theatres were also used for other surgical interventions that may be required during and after delivery.

Discharge

Arrangements were in place so that discharge was not delayed. A maternity discharge lounge facility was provided within the maternity ward. This meant that beds would not be occupied by patients who had been assessed as being ready for discharge. There were not any patients present in this area during our visit. However, we did see that the area had been equipped to make it comfortable for patients.

Senior staff told us that there had not been any concerns in relation to obtaining medication that had been prescribed for patients on discharge. This meant that when a patient was ready for discharge, the trust could respond without any unnecessary delays.

Are maternity and family planning services well-led?

Lessons learned

We saw evidence that leadership responded to, and learned lessons from, serious incidents. For example, in response to a recent 'never event', further training and staff competency assessments had been undertaken for all medical and midwifery staff involved in the procedure to which the incident related. The trust had also responded in a timely manner after a concern was raised about a significantly higher than expected number of new mothers having been readmitted to the hospital following discharge. A subsequent investigation revealed that 39% of the maternal readmissions had been coded incorrectly. The trust took action in response to several of the other reasons for readmission (for example wound care).

The trust used staff meetings, team briefs and a 'risk newsletter' to communicate information about lessons learned from incidents. It also posted memos in staff areas throughout the hospital to increase learning and reduce the risk of further incidents of a similar nature.

Support to staff

Most staff told us that they felt supported within their job roles. They told us that their responsibilities were clearly defined, and it was evident that they had a good understanding of them. We noted that staff meetings were held weekly. This included meetings for junior and senior nursing and medical staff. These provided an opportunity for staff to discuss any issues affecting the service and their work there. Any identified shortfalls in the service or incidents that had occurred were discussed so that staff were aware of the improvements that were needed.

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

New Cross Hospital offered a children and adolescent in-patient service for patients between the ages of 0 to 19 years. The service consisted of a 22-bedded paediatric ward, a six-bedded paediatric assessment unit and a 26-bedded neonatal intensive care unit. The hospital carried out planned and emergency paediatric surgery and ran a variety of outpatient clinics. There were separate facilities for patients who attended the hospital's accident and emergency department.

The Neonatal Intensive Care Unit provided the whole range of medical neonatal care for the local population, along with additional care for babies and families referred from outside of the local area. The unit had seven intensive care cots, seven high dependency cots and 12 special care cots. Parent's accommodation was available. There were around 450 admissions per year, of which approximately half were premature babies and half were babies with other problems such as infection or low birth weight.

The paediatric ward had 17 general inpatient beds, four high dependency beds and an emergency room. There were 10 single rooms for isolation purposes. The paediatric assessment unit as located next to the paediatric ward. Parent's accommodation was available.

Summary of findings

Parents told us that they were happy with the care and treatment that the hospital provided. They told us that staff listened to them and treated them with respect. They also said that staff were available when they needed them. They told us that they were actively involved in delivering their child's care. Most parents told us that communication between staff and them was good.

On arrival at the hospital, staff assessed patients' needs in an appropriate and timely manner. They planned and delivered care and treatment in line with patients' individual needs.

Systems were in place to ensure patient's safety. This included the management of staffing levels and skill mix to ensure that sufficient staffing was available to

Overall, there were effective systems in place to reduce the risk and spread of infection. However, we noted some concerns in relation to poor hand hygiene and the cleaning of the toilets on the children's care ward.

The trust did not employ a specialist to specifically support children with learning disabilities. There was one full time person who supports adults and children across all departments in the trust. This meant that staff with the specific skills to provide care and support to this group of patients may not be available when needed.

Services for children & young people

Are services for children & young people safe?

Staffing

Parents of patients told us that staff were available at the times they needed them. An electronic staff rostering system was in place and this helped to support effective planning of staff numbers and skill mix on any given shift. The parent of a patient on the paediatric ward told us, "Staff are often busy, but they are always available to us."

The trust told us that at the time of the inspection it had a shortage of staff throughout paediatric services. This was confirmed during discussions with the staff team and by our review of staffing rotas. The trust gave a number of reasons for the shortage, including staff maternity leave and long term sickness. The trust had included this issue on its risk register and had taken action to ensure patient safety.

All registered nurses working within inpatient paediatric service had paediatric qualifications. This meant that they had additional skills to provide care and treatment for young patients. Plans were in progress to recruit additional nursing staff. A number of new staff had recently been appointed and pre-recruitment checks were being undertaken. This meant that the trust was checking that they were suitable to work at the hospital.

The trust had introduced a 'bank' of staff (staff who work to fill any gaps in the rota). This meant that it could call upon these staff in times of staff shortage or unexpected demand. We were told that the staff on the bank rota were registered paediatric nurses and had received inductions into the areas of the hospital where they worked. This meant that staffing levels were maintained by staff who had been assessed as competent.

There were robust arrangements to deal with staff shortages and patient numbers reaching full capacity: staff had guidance on the order of actions to take should the need for this arise. Senior staff had a good understanding of this escalation process, and it was reviewed daily. The escalation process had been implemented during the first two days of our inspection, which meant that the department would accept no further admissions during that period of time. This demonstrated that the trust had assessed and taken action in relation to the number of staff available to provide care and treatment to the patients within the hospital at that given time. This was in order to ensure patient safety.

Medication

Senior staff told us that there had been a recent increase in medication errors within the paediatric service. This included both prescription and administration errors. In response to this, the trust had taken appropriate action, including enhanced further training for staff responsible for the prescribing and administering of medicines and the undertaking of medication administration competency assessments. The trust had also reviewed the timing of 'drug rounds' to ensure protected medication administration times. This would reduce the risk of further incidents of a similar nature. Recently, the trust carried out a medication audit and found that that there had been improvements.

Environment and hygiene

Most areas of the paediatric service were clean and tidy. There were hygienic hand washing facilities, and staff had access to protective personal equipment (gloves, aprons and eye protection). Arrangements were in place for the safe disposal of sharp and contaminated items. Equipment was stored hygienically, ready for the next patient's use.

Single occupancy rooms were available for patients who had infections, or for those who were susceptible to contracting infections from others. Cleaning schedules were in place to ensure that any high risk areas were maintained to a hygienic standard. However, despite this, on the second day of our inspection, we saw that some of the toilets in the paediatric ward were dirty. Cleaning checklists showed that the toilets had not been cleaned for at least 24 hours. We also observed a few examples of poor hand hygiene among staff and cubicle doors being propped open by clinical waste bins. This could compromise patients' health and safety. However, staff told us that the propping open of doors by waste bins was done so that multiple-bedded area could be staffed as well as the cubicle areas. This resulted in all the patients being nursed in the cubicle area, the majority of whom were not infection risks but still need to be observed, this was considered a pragmatic response to deal with the impact of staff shortages.

Services for children & young people

Are services for children & young people effective?
(for example, treatment is effective)

Assessment and care plans
Medical and senior nursing staff had undertaken assessments of patients' care needs on admission to the hospital. This was so that care and treatment was effectively planned to meet patients' individual needs. Staff had used assessment information to write nursing care plans and risk assessments. These individual plans were also written with the involvement of patients and their families. This meant that patients would receive care and support in the way they preferred.

Nursing care plans included specific instructions for staff to follow in order to meet identified care needs. Staff had a good understanding of the content of these plans. Staff kept comprehensive healthcare records. These outlined the care and treatment patients received and their health progress. Staff also recorded changes to treatment plans.

Risk assessments
Staff planned and delivered care and treatment in a way that ensured patient safety and welfare. Risk assessments identified individual risks specific to the care and treatment the patient received. This included the safety and availability of medical equipment used as part of their treatment. Staff had undertaken skin assessments and pressure sore risk assessments, and they updated these regularly. They kept comprehensive records of their observations of patient's cannula sites. This reduced the risk of tissue injuries and ensured that patients received effective care.

Continuity of care
Staff had handover sessions that included both verbal and written information from one staff team to the next. This ensured that patients had effective continuity of care and were cared for by staff who had up-to-date information about them. There were written records of discussions that had been held during doctors 'ward rounds'. This meant that all staff would have up-to-date information about patient's treatment plans. A parent on the paediatric ward told us, "We have seen the doctors regularly."

Family-based care continued after discharge, with support being provided by the children's community service. All patients with life limiting illnesses (illnesses that shorten a child's life) had a named children's community nurse. This promoted continuity of care and could facilitate earlier discharge from hospital. We spoke with a senior staff member of the community team, and it was evident that they had a good understanding of the benefits of this service in promoting continuity of care. This showed that there were good links between the acute and community services, which increased the effectiveness of the care and treatment provided in hospital.

Coordinating transfers
The trust told us that recent activity within the neonatal unit had been low. On the morning of the second day of our inspection, there were 21 patients on the unit and five empty cots. There were some patients who did not live locally and were waiting for cots to be available within their local hospitals. We noted that staff had a good understanding of their role in coordinating the transfers and the importance of this to the patients' families. Systems were in place to ensure that all necessary information about the patients was relayed to the receiving hospital on transfer. Electronic medical notes were sent out directly and nursing transfer checklists were completed. This demonstrated that discharge arrangements were effective.

Are services for children & young people caring?

Staff provided care and treatment in a caring and sensitive manner. There were good interactions between staff, patients and their families. Parents of patients on the paediatric ward told us "Our experience on the ward has been positive. The nurses are busy but they always have the time to answer our questions and provide care" and "Everything has been very good, staff have been very helpful."

Information available
Patients and their families received written information on admission to the hospital that included information about the types of services and facilities provided there. Information about the neonatal unit was also available on the trust's website. Information was available in a range of languages so that more people could access it.

Information of interest to patients and their families was on display throughout the hospital. This included: details of

visiting times; information about access to the play areas and education facilities; information about other organisations that provide support to patients and their families, including child protection support agencies.

Family-centred

Care within the hospital's paediatric service was family-centred. Parents told us that they were actively involved in their child's care and that staff provided support that enabled them to do this. They said that staff explained care and treatment and they took the time to answer any questions. Specialist staff had an important role in delivering parent education, for example, in relation to breastfeeding. This meant that parents would have the skills and confidence to continue with their child's care following discharge. Parent education information was also on display throughout the hospital. Parents of patients on the paediatric ward told us: "Whilst on the ward I have been involved in providing my child's care. Staff have informed me of my child's care plan and I have been involved in discharge planning" and "They have explained the care and treatment and offered reassurance."

Feedback

There was a 'feedback tree' on display in the paediatric ward. This included comments from patients and families about their experiences of using the service. Most of the feedback was positive. Senior staff told us that arrangements were in place to follow up any negative feedback, so that actions could be taken. A recent example of action taken in response to patient's feedback was that menus had been changed to include suggestions that patients and their parents had put forward.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Arrival

On a patient's arrival at the paediatric assessment unit, a senior paediatric nurse would carry out triage, and then a senior doctor would carry out an assessment. This meant that decisions could be made about a patient's care and treatment pathways. Medical cover was provided within this unit at all times during the day and overnight. A parent told us, "We arrived at the hospital in the middle of the night. We was seen promptly and sent home with advice to return should our child's health deteriorate. We were satisfied with this advice."

Pre-assessment clinics were held for young patients prior to planned admissions for operations. This reduced the time spent on the day of arrival for the operation.

Education

There were on-site educational facilities to help patients continue with their education while they were receiving inpatient treatment. This facility was run by designated staff and the unit had close links with staff from patients' own schools and colleges.

Outpatients

Patients in the paediatrics outpatient department had mixed views about whether the trust kept them informed about dates of hospital appointments. Most of the parents that we spoke with said that they had received appointment quickly. Comments from parents included "We didn't have to wait long for our appointment. There was good communication from the trust so we knew what to expect when we arrived today," and "We received our appointment in the time expected."

Communication

However, one parent told us that they had waited approximately 12 months to hear from the trust regarding a date for their child's operation. They said that they were not concerned about the length of time taken for the actual appointment, but they were concerned that the trust had not keep them informed with progress on the operation date. They told us, "After waiting so long, we felt we'd been forgotten. We then had just three weeks' notice of the operation date, which we didn't feel was a reasonable time to make all of the arrangements needed at home before the admission."

Are services for children & young people well-led?

Dealing with incidents

There were robust systems in place to ensure that any incidents that occurred at the hospital were dealt with in an appropriate manner. This included policies, procedures

and monitoring of incidents that had occurred. Staff told us that they knew how to report an incident if one took place. The trust investigated serious incidents so that it could identify the causes.

Reports of the investigations were presented to the Clinical Governance Committee, the Board of Directors and the Commissioner of the Service. The trust told us that that there were systems in place to make improvements and that staff received feedback about the outcomes of investigations. We noted that the trust had for a number of years reported incidents to the National Reporting and Learning Service run by the National Patient Safety Agency.

Quality walkabout

We were told that senior trust members and staff had recently conducted a 'quality walkabout' on the neonatal unit. As well as looking at environmental and safety issues, this also involved speaking with patients' families. It enabled senior trust members to engage directly with frontline staff and to make direct observations of clinical issues. Reports had been written based on the findings, but these were not on display for patients' families to read.

High risk issues

Robust arrangements were in place for the management of high risk issues that affected the trust. For example, the trust had proactively responded to current concerns in relation to staff shortages and bed occupancy. It told us that it had not identified any trends in staff shortages in the paediatric service that were related to specific days or hours of the day. Robust arrangements were in place for management of staff sickness and their return to work.

Senior nursing staff

Senior nursing staff told us that they felt supported within their job roles. They told us that their responsibilities were clearly defined, and it was evident that they had a good understanding of them. Staff meetings were held regularly. This included meetings for junior and senior nursing and medical staff. These provided an opportunity for staff to discuss any issues affecting the service and their work there. They were an opportunity to discuss identified shortfalls in the service or incidents that had occurred so that staff was aware of the improvements that were needed. Management passed information to staff via 'team briefs', email and memos on display within staff areas on the wards. This informed staff of what was happening in the hospital, so that they could implement any changes in practice that were needed.

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

New Cross Hospital had access to a palliative care team who worked across the hospital and community. In the event that a patient required end of life care, the team offered support to the patient and their carers to coordinate their care either at hospital or in the community.

The team also supported hospital staff and other professionals to improve any of a patient's symptoms. It provided training in palliative care and specialist nursing procedures. The team was available five days a week to see patients on all inpatient wards.

We talked to staff from the palliative care team as well as staff who were receiving their support.

Summary of findings

Staff were caring and sensitive to patients' needs. The trust had a specialist palliative care team who supported staff on the wards providing end of life care. Almost all patients referred to the service were seen on the day of referral. Staff spoke highly of this support and felt this teamwork helped them to provide safe care. However, staff did not always complete documentation, which meant that patients' wishes might not always be followed. The trust acknowledged that there were still improvements to be made to end of life care, and it had developed a strategy to support this.

End of life care

Are end of life care services safe?

DNAR

We looked at how the trust recorded decisions regarding cardiopulmonary resuscitation (CPR) and Do Not Actively Resuscitate (DNAR) orders (this is when a patient states that they do not want to be revived if their heart stops beating or they stop breathing). We looked to see if patients and relatives were able to make informed choices and whether the decisions were communicated efficiently and effectively. We looked at records to see how staff had recorded decisions.

Documentation

Documentation did not clearly set out the discussions that were required regarding the associated risks and any concerns the patient may have. They did not show which relative had been involved in discussions, the patient's signature of consent was not always present and the medical signature in all cases did not state the position the person signing held in the trust. The recording of DNAR was not fully completed. This meant patients' decisions might be overlooked or DNAR might be granted without their knowledge. Nurses on the ward were not aware that documentation was incomplete. At the time of the inspection, there was no data available for the trust's DNAR audit, which included feedback from relatives and patients.

Palliative care team

Wards were able to access support from the specialist palliative care team at the trust. They helped staff to care for people nearing the end of their life. Staff told us that the team provided specialist advice to the ward-based nurses and doctors on pain and symptom control for their patients. Nursing staff told us that the palliative care team provided emotional support for the patients and their families when necessary. They also supported the staff with breaking bad news and emotional situations. We were told on one ward that some of the senior staff had attended the local hospice to receive up-to-date training and advice. This meant that patients received appropriate care and treatment.

Are end of life care services effective?
(for example, treatment is effective)

Cancer patient experience

The trust had overseen and updated actions being taken to improve the cancer patient experience at the hospital, following the results of the 2011–2012 National Cancer Patient Experience Survey. The trust described the results as disappointing. For thirteen of the 70 questions, the trust was in the lowest 20% of hospitals, and it was only in the top 20% for three questions.

The trust introduced a programme to improve the cancer patient experience in 2011, and this continued to date. The effect of this improvement programme would not have been realised in the 2011–2012 survey results, but they were expected to become evident through improved results in the 2012–2013 patient survey.

Clinical reviews of deaths

The trust commented in its 2013 Annual Report that it would continue to carry out clinical reviews for all inpatient deaths.

National audit

The trust participated in the National Care of the Dying Audit – Hospitals in 2008 and 2011. The most recent results were published in December 2011 and showed a significant improvement on the previous national audit. It was 1% away from being in the top 25% in a further two KPIs and scored the same as the national average in the other KPI.

Palliative and Supportive Care Strategy

The trust recognised that there was still room for improvement. It had a Palliative and Supportive Care Strategy, which set out its approach to palliative and end of life care for all patients with life limiting illnesses. The trust aimed to ensure that all patients with an advanced life limiting illness received high-quality personalised care at all times, including symptom control and psychological, social and spiritual care.

Are end of life care services caring?

Staff were caring and sensitive to patients' needs. For example, during a ward visit we observed a nurse interacting with a patient in a side room. The nurse acted in a warm, friendly and compassionate manner, ensuring that

End of life care

the patient had all they needed with them before they left the room. We met with the palliative care team, who spoke of their positive team work with the ward staff and their ability to guide and support.

Gold Standard Framework (GSF)

The trust informed us that it was introducing the Gold Standard Framework (GSF) into the hospital for end of life care. The National Gold Standards Framework Centre in End of Life Care is the national training and coordinating centre for all GSF programmes, enabling generalist frontline staff to provide a gold standard of care for people nearing the end of life. This showed that the trust was taking into account published research and guidelines in this area.

Care for relatives

We were concerned about the trust's ability to care for relatives after a person died. We visited the bereavement office and mortuary viewing room. The office was business-like and lacked a welcoming and peaceful ambiance. The viewing room was clinical and uni-faith. It did not demonstrate a compassionate setting for relatives at a time when people's emotional state needs to be considered. We were told that the staff in the bereavement office had no specific training for the role.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Liverpool Care Pathway

We looked at how the trust had responded to recent changes to the use of the Liverpool Care Pathway (LCP). The trust board report dated 23 September 2013 demonstrated that the trust had taken note of the Health Minister's recommendations. The lead clinician for Palliative Care undertook a review of all inpatients on the LCP at that time. One patient was found to be on the LCP, but the trust reported that their care demonstrated that the LCP had been used appropriately. As part of the LCP review, the medical director sent an email to all consultants to remind them of the importance of following the guidance on its use.

The trust did identify that further work was required around the management of patients when more than one specialty was involved in an individual patient's care. The trust also reported that there was currently no out-of-hours, on-site palliative care support for the hospital. However, one nurse told us that staff could contact the local hospice for advice outside their normal working hours. The trust told us it would continue to use the LCP until such time that an alternative system was recommended.

We were told that the trust had an end of life care education and pathway facilitator who had successfully completed a level 6 health assessment module. They had commenced a non-medical prescribing course which would assist the palliative care team in their level of patient support. This meant that patients would have better access to the most appropriate level of care.

Referrals

The Specialist Palliative Care Multi-Disciplinary Team Annual Report for June 2012–2013 reported that the trust saw 98% of referrals on the same day and 96% within two days. The trust was therefore meeting targets.

Are end of life care services well-led?

The trust had identified end of life care as one of its strategic priorities, as set out in the Annual Plan 2012/13. Each of the priorities was supported by various projects and schemes. A nominated director lead monitored the progress of the strategy through a quarterly progress report to the Change Programme Board. The report outlined performance against each individual priority. This showed that the trust was putting end of life care high on the agenda and recognising its importance, but the impact of this on the quality of care was not evident during our inspection

The trust participated in the National Care of the Dying Audit of Hospitals. One of its aims was to support the Wolverhampton Clinical Commissioning Group in supporting Nursing and Care Homes. It planned to reduce the unnecessary admission of patients in the 'end of life' phase from care homes to hospital, in particular emergency admissions. This showed that the trust was reviewing the quality of this service and had taken steps to address some of its shortcomings, but there is further work to do.

We were told that at the time of the inspection the trust had medical representation for five days a week to support the staff in ensuring that patients care was reviewed and suitable for their needs.

End of life care

The results of the CQC National Survey of Adult Inpatients in the NHS (2012) helped the trust to improve its performance. The trust's scores were comparable to those of other trusts. For example, the trust scored 7.9 out of 10 for 'feeling that hospital staff did all they could to help control their pain, if they ever were in pain'.

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

A wide range of outpatient services were available at New Cross Hospital.

We visited the main outpatients department that hosted a number of clinics such as neurology and pain management. We also visited a midwifery led clinic.

We talked to 23 patients and five members of staff and received a number comment cards.

Summary of findings

The main outpatients environment was not as welcoming as other parts of the hospital. There was limited information and facilities for patients. We were also concerned about the cleanliness of some parts of the department. Outpatients had not had a substantive matron in post for over six months, however, the trust told us that regular support had been offered by another matron. The trust had removed one band seven nurse as part of a cost improvement programme. Two part-time band six nurses had been running the department. The part-time band six nurses told us they had received limited support over this period.

Despite this, patients and carers were overwhelmingly positive. They felt that the appointment system was effective and that appointments are rarely cancelled. Although we were told that clinics can often over-run. Many patients talked about problems with parking and how this can impact on their ability to arrive on time for their appointment.

Outpatients

Are outpatients services safe?

Patients said they thought the department was clean and tidy. Hand sanitiser was available for patients and their carers entering the department, but many people entering the department did not see it, because it was not adequately signposted.

Staffing

Patients also told us they felt there were enough staff to meet their needs.

Staff observed patients' confidentiality. We did not see any unattended notes and the reception area maintained confidentiality, even though there was limited space.

We were told the department is in the process of getting one member of staff trained as a safeguarding (protecting patients from abuse) representative. We did not observe any information relating to safeguarding in the department.

Infection control

There were formal measures for hand washing, and the sister in charge told us the department is rated as 'green' for infection control.

We found the cleaners' room to be inadequate and a potential infection control risk. For example, the cleaners told us they hand scrub the floor buffers and drain over the dirty sink. There was then nowhere for them to wash their hands. There were no written cleaning schedule in place and we found some examples of poor cleaning practice. For example, we found dust on all high level surfaces, the lower surface of some clinical trollies had not been cleaned and a patient trolley in the corridor had thick dust on all rails and fixings.

Equipment

The cardiac arrest trolley was stored in a room which contained the drug cupboards for the department. The key code for the door was disabled to allow easy access to the cardiac arrest trolley, but this meant that the safe storage of medicines in the department was compromised.

Are outpatients services effective?
(for example, treatment is effective)

Patients said they felt that the outpatient appointment system was effective, and no one reported cancelled appointments to us. Patients said appointments are usually prompt. However, a number of patients did tell us that they had experienced delays in the past.

We were told outpatient sessions frequently ran late, but there was no formal mechanism to monitor or control this. Sister told us Tuesdays and Thursday were the worst days for overrunning. Patients told us that if there were delays staff kept them informed. Consultants sometimes turned up late, especially consultants travelling from Birmingham, as traffic can be an issue. In such cases, outpatient staff waited 30 minutes before trying to find a missing consultant. The sister in charge told us the last two incidents they had reported were consultants not turning up for clinic. We were unable to find out the exact dates of these incidents or who the consultants were.

Staff at the clinic told us patients can still be seen if they arrive within 20 minutes of their appointment time. We were told if a patient had a genuine reason for being late they were usually seen. The most common reason given for being late was problems with parking at the hospital. It was not clear how the clinic was managed to accommodate this problem.

Are outpatients services caring?

Patients felt that staff were caring and responsive to their needs. All the patients we spoke to in the department were happy with their care, and almost all the comments we received on the comments cards were positive. All the patients told us they felt informed about their treatment and that the medical staff listened to them. One patient told us that the doctor gave them their business card and told them to ring if they had any questions. Patients also told us that communication between the hospital and their GP was good.

Outpatients

Are outpatients services responsive to people's needs?
(for example, to feedback?)

Environment
The department's environment was unwelcoming. Signage at the entrance to the department did not clearly tell patients where to report. The reception area has privacy screens either side of the desk, which makes it difficult to see the reception area when you enter the building. We noted that there was limited information for patients in and around the department. For example, we did not see any information relating to safeguarding or how patients could make a complaint. We did note, however, that there was lots of relevant and helpful information provided in the maternity clinic we visited. Patients and carers said they did not know how to make a complaint, and many did not know what PALS was.

Café
There was a WRVS café in the main waiting area. We were told it rarely opened, as the WRVS does not have enough staff. There were two vending machines also in the main waiting area. One had a sign on it saying that the equipment was not the responsibility of the hospital. There were no other refreshment facilities in the department. We were told patients could access water or staff would fetch hot drinks if they had waited a long time. However, there were no water dispensers in the waiting areas and no signs informing patients they could ask for water or hot drinks. People we spoke with told us they had fetched drinks and snacks from the main hospital site.

Learning difficulties
We asked about support for patients with learning difficulties. We were told they could contact a learning disability nurse, but it was not clear how they would do this. As previously mentioned, at our listening event patients with learning difficulties told us they felt as though there was not enough support for them whilst they received care.

Are outpatients services well-led?

We could see that the clinics were running smoothly, and there was no evidence that clinics were over-booked. Staff told us that some clinics experienced delays and had strategies in place to manage them, but it was not clear if there were any long-term plans to resolve these issues.

Staffing
Two part-time band six nurses ran the outpatients department. The department had had a band seven post but this had been removed as part of cost improvement measure. Outpatients had not had a substantive matron in post for over six months, however, the trust told us that regular support had been offered by another matron. The matron had been a vacant post until recently, so the two band six nurses had been managing the department with limited support.

Complaints
The sister in charge on the day of our inspection was not clear about complaints procedures or the role of PALs. However, she did say that if a patient did have a concern they would try to resolve it informally by talking it through with the patient in the first instance.

Quality assurance
We were not able to see any quality assurance information (such as how clinics were performing against targets) within the clinics. We were told that information from hospital-wide never events was shared at a monthly directorate governance meeting. Staff also told us that the department has a team meeting every morning.

Good practice and areas for improvement

Introduction

The trust has a number of key strengths, most notably in the domains of safety, caring and well-led. We found many positive aspects in these areas which are noted below. The inspection team felt that effectiveness and responsiveness are areas which could use improvement.

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- Patients praised staff on their caring and compassionate approach, and staff spoke positively about working for the trust.
- The inspection team was impressed with the trust's response to the never events in theatres and the steps taken to minimise the likelihood of them reoccurring.

Areas in need of improvement

Action the hospital MUST take to improve

- The hospital must take action to improve the responsiveness of care for older patients. We were concerned that older people's care, surgical and dementia wards were not sufficiently staffed, particularly at night, where there was one registered nurse for every 10 patients. We felt this was impacting the safety and effectiveness of care. The trust must also ensure its dementia care bundle is implemented consistently on every ward.
- The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence. This issue has been included on the trust risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas. Further work is needed to improve staffing levels in the maternity ward, as it is impacting on the responsiveness and effectiveness of staff.

Action the hospital COULD take to improve

- Infection and hygiene controls
- Following guidelines for treatment of patients with dementia
- Documentation of decisions made about whether to resuscitate a patient
- Responsiveness to patient feedback
- Clear focus at Board level on a short to medium-term improvement strategy

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010: Care and Welfare of Patients. People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by ensuring the welfare and safety of the service user. Regulation 9(1)(b)(ii).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010: Complaints The provider has not brought the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format. Regulation 19(2)(a).