Care Quality Commission

Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Inadequate
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Inadequate
End of life care	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Worcestershire Acute Hospitals NHS Trust was established on 1 April 2000 to cover all acute services in Worcestershire, with approximately 885 beds spread across various core services. It provides a wide range of services to a population of around 580,000 people in Worcestershire, as well as caring for patients from surrounding counties and further afield.

Worcestershire Acute Hospital NHS Trust provides services from four sites: Worcestershire Royal Hospital, Alexandra Hospital, Redditch, Kidderminster Hospital and Treatment Centre and surgical services at Evesham Community Hospital, which is run by Worcestershire Health and Care NHS Trust.

The trust was rated overall as inadequate and entered the "special measures" regime based on the initial inspection from 14 to 17 July 2015. Special measures apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Kidderminster Hospital was rated as requires improvement overall during this period.

As part of a scheduled re-inspection of the trust, we carried out a further comprehensive inspection of Worcestershire Acute Hospitals NHS Trust from 22 to 25 November 2016, as well as an unannounced inspection from 7 to 15 December 2016.

On 27 January 2017 we issued a section 29A warning notice to the trust requiring significant improvements in the trusts governance arrangements for identifying and mitigating risks to patients.

Overall, we rated Worcestershire Royal Hospital as inadequate, with three of the five key questions we always ask being judged as inadequate.

Our key findings were as follows:

- Crowding and poor flow were having a significant impact on patient care and experience. The flow of patients in the emergency department (ED) was often blocked by internal capacity issues in the hospital. The trust was consistently not achieving the national target to admit or discharge 95% of patients within four hours of arrival.
- Due to patient care being carried out in corridors and small cubicles in the ED there was a lack of privacy and dignity for patients in these areas.
- There were not enough consultants to provide 16 hours of consultant cover within the ED each day, in line with national guidance.
- Not all staff cleaned their hands before and after contact with patients and some staff did not change their gloves or aprons after each task. This meant that infection prevention and control practices were not in line with trust policy or national guidance throughout the hospital.
- Staff did not feel valued or listened to by divisional and executive teams. This led to low morale and frustration amongst staff.
- Robust and appropriate systems were not in place for carrying out and monitoring venous thromboembolism (VTE) assessments, which contravened National Institute for Health and Care Excellence guidance.
- Medical notes were not always locked away safely.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.
- Safeguarding children training compliance was low throughout the hospital and not in line with national guidance.
- Staff were unaware of female genital mutilation and child sexual abuse. There was a risk that staff would not recognise when a child was being abused or exploited.
- Assessments for paediatric patients' requirement of 1:1 care from a mental health nurse were not always undertaken and care was not consistently provided by a member of staff with appropriate training.

Summary of findings

- Not all equipment had been safety tested and the emergency neonatal trolley in the delivery suite was not always checked daily.
- Medicines management was poor with medicines that required cool storage being stored in fridges which were either below or above the manufacturers recommended temperature. Emergency medicines were not protected from tampering
- There was inadequate review and document control of protocols for standard x-ray examinations. Some protocols were in a handwritten format with alterations made by various members of staff without apparent ratification.
- Patient feedback during our inspection was very positive about the nursing and medical staff that provided their care. Patients were treated with compassion and respect by staff
- There was a positive culture of incident reporting and incidents were reported appropriately and in-line with trust policy. Staff said they received feedback after reporting an incident. However we found in the ED department some senior staff discouraged the reporting of incidents relating to overcrowding.
- The critical care team were able to ensure safety across the county wide service by transferring skilled staff to assist with the management of patient care according to need.
- We observed close working between the specialist palliative care team and ED staff to identify patients at the end of life and provide specialist support. The trust was one of ten that had been chosen to participate in a quality improvement partnership with The National Council for Palliative Care and Macmillan Cancer Support.

There were areas of poor practice where the trust needs to make improvements.

Action the hospital MUST take to improve

- Ensure patients' privacy, dignity and confidentiality is maintained at all times. For example, patients staying overnight in the gynaecology assessment unit.
- Ensure that patient documentation, including risk assessments, are always completed accurately and routinely to assess the health and safety of patients. This should include elderly patient risk assessments, dementia assessments, venous thromboembolism assessments, sepsis bundle assessments and fluid balance charts.
- Use a standard risk assessment to assess and identify the needs of patients admitted to wards with mental health needs. This must include details of whether the patient requires 1:1 or 2:1 care from a specialist mental health nurse, and the level of care provided.
- Ensure nursing documentation on high dependency units is contemporaneous with detailed accounts of the day's activities completed.
- Ensure that patient weights are recorded on their drug charts.
- Ensure that there is clear oversight of the deterioration of patients and the National Early Warning Score chart is completed accurately.
- Ensure that the Paediatric Early Warning Score charts are consistently completed in a timely manner and accurately.
- Ensure that patients are escalated as a result of the Paediatric Early Warning Score where they trigger a deteriorating patient.
- Ensure that the eligibility criteria for the clinical decisions unit is followed to ensure appropriate patients are admitted.
- Ensure there is access to 24-hour interventional radiology services.
- Ensure staff are aware of ligature points.
- Establish identification of female genital mutilation training that is to be completed by all staff working in children and young people's services.
- Ensure that patients under child and adolescent mental health services receive care from appropriately trained staff at all times.
- Ensure that staff providing care for children requiring continuous positive air pressure or AIRvlo have appropriate training or up to date competencies to use this equipment safely.

Summary of findings

- Ensure that there is an appropriate mental health room in the emergency department to care for patients presenting with mental health conditions that complies with national guidance.
- Ensure that flow in the hospital is maintained to prevent patients being treated in the emergency department corridors for extended periods of time.
- Ensure that children are not left unattended in the emergency department paediatric area.
- Ensure that there is a robust system in place to make sure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that equipment is checked as per policy, particularly in midwifery services.
- Ensure that patients are cared for in a safe environment that has the appropriate equipment to facilitate care to a deteriorating patient.
- Ensure that medicines are always stored within the recommended temperature ranges to ensure their efficacy or safety.
- Ensure prompt investigation of any medicines which are unaccounted for.
- Review arrangements around storage of intravenous fluids for emergency use to ensure patient safety.
- Ensure that medicines are always administered to patients as prescribed.
- Ensure infection prevention and control procedures are always carried out as per trust policy and national guidelines.
- Improve performance against the 18 week referral to treatment time, with the aim of meeting the trust target.
- Improve performance against the national standard for cancer waiting times. This includes patients with suspected cancer being seen within two weeks and a two-week wait for symptomatic breast patients.
- Ensure they are carrying out patient harm reviews to mitigate risks to patients who breach the referral to treatment times and cancer waits.
- Ensure safeguarding checks are made consistently.
- Ensure information relating to the children at risk register is accessible.
- Ensure that incidents are accurately reported and investigated.
- Ensure that staff receive appropriate training to enable the correct categorising of incidents.
- Ensure that staff are not discouraged from reporting incidents relating to capacity and corridor care.
- Ensure that incidents that need reporting to external authorities are completed.
- Ensure there is an embedded risk assessment process to determine the criteria for patient moves to non-medical wards.
- Ensure all mortality and morbidity meetings are recorded and lessons are learnt.
- Ensure there are systems and processes established in surgical service to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.
- Ensure divisional management teams are aware of patient harm reviews to mitigate risks to patients who breach the referral to treatment times and cancer waits.
- Ensure divisional management teams have oversight of the patient waiting lists and of initiatives and actions taken to address referral to treatment times and cancer waits.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Develop a clearly defined business plan for paediatrics, which considers the risks to the service and incorporates a vision and plans for service improvement. The plan must have clear objectives and milestones, supported by actions to ensure objectives are realised.
- Ensure the risk register identifies and mitigates all risks.
- Ensure there is a review of the paediatric assessment area and subsequent admissions to identify and resolve potential issues with flow and capacity.

Summary of findings

- Ensure the bed management plans for children and young people, devised to deal with escalation issues for staffing shortages or high bed occupancy, is up to date.
- Ensure there is a strategy is in place for diagnostic and imaging services that staff are aware of.
- Ensure patient notes are stored securely and safely.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets the trust target of 90%.
- Ensure all staff receive an annual appraisal.
- Ensure there are sufficient registered children's nurses in post to make certain that the emergency department has at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments.
- Ensure that only an appropriately trained staff member is left in charge of a ward to care for patients.

In addition, the trust should:

- Ensure lessons learned from incidents are shared.
- Ensure all equipment is in date and fit for purpose.
- Ensure that staff follow the policy on the use of the 'I am clean stickers', particularly in the emergency department.
- Ensure that all needles and cleaning chemicals are kept securely.
- All departmental policies and procedures, including safeguarding policies, should be reviewed and revised to ensure they are reflective of up to date guidance.
- Ensure that standard operating procedures are in place and are correctly followed, including care of patients within the clinical decisions unit and care of patients within the emergency department corridor.
- Ensure staff are familiar with the major incident policy and undertake specific training or complete exercises.
- Ensure that staff are aware of the escalation policies in the trust and were clear on what steps should or be taken during times of increased demand in the emergency department.
- Ensure that staff are aware of how to use panic buttons or what response would be received.
- Ensure that the emergency department door which ambulance patients are bought in by is not used as a shortcut for other staff.
- Ensure there is evidence of mitigating actions taken at trust wide and divisional level to significantly improve the care and environment in the emergency department to ensure patients are safe.
- Review the agency induction proforma.
- Ensure NHS Safety Thermometer data is displayed.
- Ensure that all medical patients have a nominated medical consultant allocated prior to discharge.
- Review the staffing levels within diagnostic and imagining ensuring adequate cover for the demands for the service, supervision of staff and suitable radiation protection supervisor cover across all sites.
- Improve the process of review and document control of protocols for standard x-ray examinations.
- Develop a clinical audit plan that includes local priorities and audits completed on a timely basis. This should include clinical audits that meet the requirements of Ionising Radiation (Medical Exposure) Regulations 2000.
- Ensure action plans include sufficient detail to address identified concerns.
- Share results and action plans from national audits with all levels of staff to improve patient outcomes.
- The maternity service should conduct audits of the care of women with termination of pregnancies and the completion of their maternal early warning score; Worcestershire Obstetric Warning score.
- Ensure that all cardiotocograph traces have evidence of fresh eye reviews every two hours.
- Ensure that patients receive pain relief in a timely way.
- Ensure that patients are appropriately assessed to have a Deprivation of Liberty Safeguard implemented, where required.
- Ensure that additional steps are taken to maintain patients' privacy and dignity when nursed in mixed sex areas and during nursing handovers.

Summary of findings

- Provide a follow up service for patients discharged from critical care with access to consultant and nurses.
- Review the choices offered to patients about where they are discharged to for continuing care.
- Reduce the number of cancelled of operations in line with the national average of 6%.
- Review the high levels of unplanned medical admission onto surgical wards, resulting in some cancelled operations.
- Put arrangements in place to limit the number of gynaecology patients being nursed on general wards.
- Review the capacity in emergency theatres.
- Ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for emergency departments.
- Ensure delays in ambulance handover times are reduced to meet the national targets.
- Ensure initial patient treatment times are reduced to meet the national target for 95% of patients attending the emergency department to be admitted, discharged or transferred within four hours.
- Ensure paediatric patients are directed to the paediatric waiting area in the emergency department.
- Ensure there are appropriate waiting room and toilet facilities for patients using the gynaecology assessment unit.
- Ensure there are clear pathways in place to support patients with complex needs, such as a learning disability and patients living with dementia, particularly within the emergency department, gynaecology and maternity.
- Ensure that staff are aware of how to access full patient information leaflets in an alternate language other than English.
- Ensure that all complaints are responded to in line with the trust policy.
- Ensure that health and wellbeing of staff is promoted, including encouragement to take their allocated breaks, particularly in the emergency department.
- Ensure that staff have an awareness of the trust's strategy.
- Ensure that senior trust wide leaders have an accurate overview of the care and environment in the emergency department.
- Ensure there is radiology representation at divisional level.
- Review the radiation protection governance and infrastructure to ensure compliance with statutory radiation regulations.
- Consider involving staff in strategic plans and developments within surgical services.
- Ensure visibility of the executive team.
- Develop a strategy to monitor the implementation of the gynaecology vision.
- Undertake a ligature audit in the paediatric department.
- Improve the process of risk rating and replacement of diagnostic and imaging equipment.
- Ensure there are consistent mortality review group meetings in order to review the Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator across the service.

Since this inspection in November 2016 CQC has undertaken a further inspection to follow up on the matters set out in the section 29A Warning Notice mentioned above, where the trust was required to make significant improvement in the quality of the health care provided. I have recommended that the trust remains in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	We rated urgent and emergency services as inadequate because: • Crowding and poor flow were having a significant impact on patient care and experience. The flow of patients in the emergency department (ED) was often blocked by internal capacity issues in the hospital. The trust was consistently not achieving the national target to admit or discharge 95% of patients within four hours of arrival. There was a lack of plans or strategies to correct this. • There were not enough consultants to provide 16 hours of consultant cover within the ED each day. • Due to patient care being carried out in corridors and small cubicles there was a lack of privacy and dignity for patients in these areas. Conversations could often be overheard and patients were expected to sleep overnight in these areas which were bright and noisy. • The department did not meet the requirements of the national "Standards for children and young people in emergency care settings". Staffing did not always meet the necessary levels for paediatric care, and paediatric patients were often left alone with no observation. • The arrangements for governance and performance management did not always operate effectively. Until November 2016, there had not been an effective governance framework to support good quality care for over a year. There was no clear process for the escalation of risks to divisional directors or the trust board. • Infection control practices were not in line with trust policy or national guidance throughout the department. • Staff did not feel valued or listened to by divisional and executive teams. This led to low morale and frustration amongst staff. However:

Summary of findings

- Incidents were reported appropriately and in-line with trust policy, even though some senior staff discouraged this. Staff knew what to report and how to report it on the electronic system.
- There was a strong team working ethos amongst staff in the ED, which most staff felt kept the department working in difficult circumstances.
- Patient feedback during our inspection was very positive about the nursing and medical staff that provided their care. Patients were treated with compassion and respect by staff throughout our inspection, despite the environment not supporting adequate dignity and privacy.
- Pharmacy provision was available seven days a week within the ED.

Medical care (including older people's care)

Inadequate

We rated medical care as inadequate because:

- Patients who required medical care but were cared for on non-medical wards did not always receive reviews from the appropriate medical team. Patients deteriorating in non-medical wards were not always escalated to the medical team in a timely manner.
- The National Early Warning Score (NEWS) is a guide used by medical services to determine the degree of illness of a patient. During our inspection, we found there was no clear oversight of deteriorating patients in escalation areas. For example, we saw that a patient with a NEWS score of eight was not closely monitored. This was not in line with the trust policy, which states that NEWS scores above five should be monitored hourly.
- Only 51% of NEWS was escalated appropriately and this was below the trust target of 95%.
- Escalation areas used to accommodate patients did not have appropriate equipment and facilities (for example, resuscitation trolley) to look after deteriorating patients.
- Equipment was not always available to meet patient needs. For example, patients who required assistance with eating were not always served their food on red trays that indicate their need for supported eating, as they were not always available.

Summary of findings

- Robust and appropriate systems were not in place for carrying out and monitoring venous thromboembolism (VTE) assessments, which contravened National Institute for Health and Care Excellence guidance.
- The governance system in relation to the management of risk did not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.
- Patient weights were not recorded on more than 50% of drug charts.
- Systems were not in place to manage the safe storage of medicines. Medication such as intravenous fluids were stored in resuscitation trolleys which were not tamper evident and these trolleys were left on corridors that could be accessed by unauthorised people.
- The systems, processes and the operation of governance arrangements in place were not effective in terms of identifying and mitigating risks to patients.
- We found records left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.

However:

- The service had a positive culture of incident reporting and there were established processes for investigating incidents.
- There was effective multidisciplinary team working.
- Staff were friendly towards patients and treated them and visitors with understanding and patience.
- Patients were well supported by staff, treated with dignity, respect, and received compassionate care.

Summary of findings

- Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were person-centred and unhurried.

Surgery

Requires improvement

We rated surgery as requiring improvement because:

- Patient outcomes were generally below the England averages and not all staff were aware of patient outcomes relating to national audits or performance measures.
- The trust had mixed performance for national Hip Fracture Database audit and the National Emergency Laparotomy Audit.
- There was no access to 24-hour Interventional radiology services.
- Not all patients had been reassessed 24 hours after admission for venous thromboembolism.
- There was variable compliance with hand hygiene and the use of personal protective equipment.
- Medical notes were not always locked away safely.
- There was a high number of medical and nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts.
- Not all staff had completed mandatory training or received an annual appraisal.
- The admitted referral to treatment time was consistently below the England average of 80%.
- The number of cancellations of operations was higher than the national average.
- There was insufficient capacity in emergency theatres.
- There were high levels of unplanned medical patients admitted onto the surgical wards, resulting in some cancelled operations.
- Patients were not always offered a choice about where they were discharged to for continuing care.
- County wide management of emergency surgery had not been fully implemented.
- There was no clear strategy for surgical services.
- There was a lack of risk management.

Summary of findings

- Staff told us there was disengagement between consultants, department managers and the divisional leaders.
- Staff felt pressured into accepting patients onto the wards when they were already full.

However:

- There was a culture of incident reporting and staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate and there were good emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.
- Treatment and care were provided in accordance with evidence-based national guidelines.
- Staff had awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and safeguarding procedures to keep people safe.
- There was a good consent process in place.
- The service had an effective complaints system in place and learning was evident.
- There was support for people with a learning disability and reasonable adjustments were made to the service. An interpreting service was available.
- Staff were caring and compassionate to patients' needs. Patients spoke highly of the care they had received.
- Patients' pain, nutrition and hydration were appropriately managed.
- The governance framework had improved.
- There were regular staff meetings at all levels and information was shared with staff.
- There was evidence of patient and public engagement.

Critical care

Requires improvement

We rated critical care as requiring improvement because:

- We found that clinical incidents were not always categorised accurately or reported externally. We

Summary of findings

saw evidence that staff remained confused as to what constituted a near miss incident and reported incidents as a near miss when patients were placed at risk.

- Outside of critical care, staff felt pressurised and unsupported. Nursing staff felt that patient care was not a priority to the trust.
- The executive team were not visible across the organisation and staff felt that the lack of a permanent executive team affected progress.
- Nursing records within the high dependency units were not always contemporaneous, with data entries being completed at the end of clinical shifts and not when events occurred.
- The clinical environment for the critical care and high dependency units did not meet all the recommendations set out in the Health Building Note 04-02 Critical care units' standards. This included limited washing and toileting facilities for mobile patients on the critical care and high dependency units.
- Staff did not always adhere to infection control and prevention practices.
- Consultants were responsible for the management of children admitted as an emergency until transfer to a children's specialist hospital was arranged.
- Patients on the high dependency units who were categorised as level two due to arterial line being in situ were not provided with additional screens or privacy when placed in beds opposite a member of the opposite sex.
- We saw that venous thromboembolism assessments were not always completed in line with recommendations, with the repeat assessment after 24 hours of admission missing.
- Mandatory training compliance did not always meet the trust target. High dependency staff had not completed critical care handbooks at the time of inspection, although these were in progress.
- Medical consultants were not always allocated to the care of patients following discharge from critical care, which affected patient follow up after discharge.

Summary of findings

- There was a limited follow up service for patients discharged from critical care with no provision of a formal medical lead clinic.

However:

- Critical care staff completed a daily safety brief where they discussed any incidents or complaints and identified learning. Learning was also shared across the service at team meetings.
- Appropriate staff regularly reviewed patients. Medical teams reviewed patients a minimum of twice daily. The critical care outreach service assisted with the monitoring and treatment planning of sick patients across the trust, providing local support for teaching and monitoring of compliance in trust wide deteriorating patient audits.
- Critical care were able to ensure safety across the county wide service by transferring skilled staff to assist with the management of patient care according to need.
- The service had implemented a weekly multidisciplinary team meeting to review patient's rehabilitation needs.
- Critical care used evidence based patient pathways, policies and protocols to provide care.
- Trust data published by the Intensive Care National Audit and Research Centre detailed that the service performed in line with similar sized organisations and as expected.
- The service provided a seven-day service with access to specialists, such as dietetics and pain specialists, for additional treatments or advice. Specialist were involved with the planning of treatments and participated in multidisciplinary team meetings.
- The service had a robust training programme for staff that included the use of a competency handbook, local training support from the practice development nurses and scenario based training.
- Patients and their relatives were treated in a compassionate, respectful manner. Staff provided privacy for relatives and patients.

Summary of findings

Patients and their relatives were supported during their stay within critical care with staff offering opportunities to discuss care and treatment.

- There were additional facilities within the critical care unit, which enabled patient's relatives or loved ones to stay on site. There were also facilities for those requiring additional support for aspects such as learning disabilities, translation services.
- Staff and relatives used patient diaries to record events. These helped patients understand what had happened whilst they were sedated.
- There were systems in place to address formal and non-formal complaints. The most relevant persons completed investigations and responses and learning shared amongst the team though open discussion and team meetings.
- Critical care had a vision of the service, which reflected the trust core values. This included the plans to centralise critical care services and build a high dependency unit.
- The service had a robust governance structure and cascaded service performance data to the trust board and to staff on the units.
- Local leaders were reported as being supportive, accessible and approachable.

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology as requiring improvement because:

- The emergency neonatal trolley in the delivery suite was not always checked daily.
- Not all equipment on the delivery suite had been safety tested.
- Not all staff had completed safeguarding children level 3 training.
- Patients had been staying overnight in the gynaecology assessment unit due to a lack of bed space.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning.
- The referral to treatment time for gynaecology patients had deteriorated and was below target.

Summary of findings

- Nominated gynaecology beds were not ring fenced which meant these patients were often nursed on general wards.
- There was no strategy to implement the vision to expand the gynaecology service.
- We identified risks on inspection that were not on the service's risk register.

However:

- The service monitored the number of open incident reports and this was below target.
- Early warning scores were used to identify deteriorating patients.
- The service had achieved UNICEF Baby Friendly Initiative level 3.
- Staff were caring and compassionate towards patients.
- The bereavement midwife provided individualised care and support to patients and families who had experienced a pregnancy loss or stillbirth.
- Local leadership were approachable and visible across the service.

Services for children and young people

Inadequate

We rated services for children and young people as inadequate because:

- Incidents were not always categorised correctly and lessons learnt not shared consistently.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning. Mortality and morbidity meetings for paediatrics were not discussed at any other meeting.
- Infection control policies were not consistently followed when caring for patients with an infection.
- Emergency medicines were not stored in tamper evident trolleys or boxes. Medicines had been reported missing; the investigation was not completed promptly to determine whether these had been stolen or were a result of an administrative error.

Summary of findings

- Risk assessments had not been consistently completed for all patients and a standard template was not used to document risk for patients with mental health needs. A ligature audit had not been undertaken.
- The women's and children's directorate had not achieved their mandatory training target of 90%. Staff were unaware of female genital mutilation and child sexual abuse. Safeguarding checks were not consistently undertaken and not all staff had completed the required level of safeguarding training. There was no clear policy on restraint and staff had not received training. Staff had limited understanding of the Mental Capacity Act 2005.
- Not all new-born babies were electronically tagged for security purposes and staff were unclear what action they would take if a young person went missing.
- Assessments for patients' requirement of 1:1 care from a mental health nurse were not always undertaken and care was not consistently provided by a member of staff with appropriate training.
- All nursing staff competency assessment records seen were out of date. There was no formal clinical supervision for nursing staff.
- Some guidelines were out of date.
- Clinical audits were not completed on a timely basis and the audit plan did not include local priorities. The action plan to improve outcomes for patients with diabetes lacked detail.
- There was a lack of planning with regards to increased activity since the reconfiguration of the service. The escalation policy had been followed but it was unclear how the increase in demand would be managed.
- The needs of local people had not been considered as part of the annual business planning cycle. Personal information for children with long term complex care needs lacked detail or had not been completed.
- There was a vision and divisional plan in place; however, this was not supported by clear objectives or actions. The governance framework was not effective. There was a lack of

information flow between committees and meeting minutes lacked detail around the content of information presented. The risk register had failed to incorporate significant risks.
- Feedback about the service was not consistently acted on. The response rate for the friends and family survey was lower than the England average and people were less likely to recommend the service.

However:

- Patients' pain was assessed and managed effectively which was an improvement since the July 2015 inspection. Patients had their nutritional and hydration needs met.
- Medications were stored securely and administered as prescribed. Patient records were stored securely. Access to the unit was secure.
- Staff who worked in the children's clinic interacted with patients and their parents in a manner which was respectful and supportive. All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- Staff interactions with patients were positive and patients were treated with dignity and respect.

End of life care

Good

We rated end of life care as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- The trust had taken action to improve the facilities in the mortuary since a previous inspection. This included replacing fridges, flooring and improving the hot water facilities.
- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life. A comprehensive programme of end of life care training was available for the full range of staff within the trust.

Summary of findings

- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members. The specialist palliative care team provided a seven day face to face assessment service across the trust.
- People were supported, treated with dignity and respect and told us they felt involved in their care. We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. People we spoke with were complimentary about the staff and told us they felt appropriately supported.
- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent. The majority (92%) of patients were seen within 24 hours and there was a good balance between cancer and non-cancer referrals.
- The specialist palliative care team worked proactively with the emergency department to identify patients who may benefit from palliative care input.
- The trust had begun to record and audit preferred place of care at the end of life and there were clear systems in place to make improvements in this area.
- The specialist palliative care team had audited complaints that had an end of life care component, identified trends and had taken action to address improvements.
- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.
- There was consistent promotion of the delivery of high quality person centred care and strong leadership for end of life care. Staff were consistently passionate about end of life care, positive about their roles and consistent in their belief that the quality of end of life care was good.

Summary of findings

- Innovations included close working between the specialist palliative care team and emergency department staff to identify patients at the end of life and provide specialist support. The trust was one of ten that had been chosen to participate in a quality improvement partnership with The National Council for Palliative Care and Macmillan Cancer Support.

However:

- Discussions around DNACPR (do not attempt cardiopulmonary resuscitation) decisions were not always sufficiently recorded within patient's medical records.
- Feedback from relatives and staff showed there had been some delays in obtaining death certificates, although we saw that this had been discussed at the meeting of the bereavement group and we were told the lead nurse was taking the lead on addressing this issue.

Outpatients and diagnostic imaging

Inadequate

We rated the outpatients and diagnostic imaging services as inadequate because:

- There was a lack of radiation protection infrastructure.
- There was inadequate review and document control of protocols for standard x-ray examinations. Some protocols were in a handwritten format with alterations made by various members of staff without apparent ratification.
- Aging and unsafe equipment across the trust that was being inadequately risk rated with a lack of capital rolling replacement programmes in place.
- There have been two patient safety incidents in the trust whereby patients had been physically injured by unsafe x-ray equipment.
- Whilst staff were aware of their roles and responsibilities with regards to reporting patient safety incidents, incident reporting in outpatients was low and where incidents had been reported, the dissemination of lessons learnt was insufficiently robust.

Summary of findings

- The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care.

However:

- Staff were dedicated and caring.
- Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support.
- The premises were visibly clean.
- The process for keeping patients informed when clinics overran was established and well managed.
- Leadership within the outpatient's team was visible however, the management of risk was insufficiently robust and further improvements were necessary.

Worcestershire Royal Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Worcestershire Royal Hospital

Worcestershire Royal Hospital provides acute healthcare services to a population of around 550,000 in Worcestershire and the surrounding counties.

There are approximately 500 inpatient and day case beds, of which 70 are maternity and 18 are critical care. The hospital provides a comprehensive range of surgical, medical and rehabilitation services, including stroke services and cardiac stenting. The trust employs 5,053 staff, including 725 doctors, 1,843 nursing staff and 2,485 other staff.

In 2015/16, the trust had an income of £368,816,000 and costs of £428,732,000; meaning it had a deficit of £59,916,000 for the year. The deficit for the end of the financial year for 2016/17 is predicted to be £34,583,000.

This was the second comprehensive inspection of the trust. The first took place in July 2015, when Worcestershire Royal Hospital was rated as inadequate and the trust entered special measures.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Secondary Care Specialist, Newcastle Gateshead Clinical Commissioning Group

Co-chair: Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants and nurses from surgical services, critical care, outpatients, palliative care and general medicine; emergency department doctors and nurses, a paramedic, a consultant radiologist, paediatric nurses, safeguarding specialists and experts by experience. The team also included an executive director, a non-executive director and a governance specialist.

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?

Detailed findings

- Is it responsive of people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We held interviews, focus groups and drop-in sessions where staff shared their experience of services provided by Worcestershire Acute Hospitals NHS Trust. We spoke with people who used the services and those close to them to gather their views on the services provided. Some people also shared their experience by email, telephone or completing comment cards.

We carried out this inspection as part of our programme of re-visiting hospitals. We undertook an announced inspection from 22 to 25 November 2016 and an unannounced inspection on 8 December 2016.

Facts and data about Worcestershire Royal Hospital

Worcestershire Royal Hospital is part of Worcestershire Acute Hospitals NHS Trust.

In 2015/16, the trust had:

- 120,278 emergency and urgent care attendances.
- 139,022 inpatient admissions.
- 588,327 outpatient appointments.
- 5,767 births.
- 2,181 referrals to the specialist palliative care team.
- 51,444 surgical bed days.
- 1,945 critical care bed days.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Worcestershire Royal Hospital provides a 24-hour, seven-day a week service. From October 2015 to September 2016 the ED saw 66,375 patients; of these attendances 11,750 (18%) were under the age of 16. Overall there had been an increase of 4% in attendances than the previous year. Paediatric attendances at Worcestershire Royal Hospital had increased over the three months prior to our inspection, due to reconfiguration of these services. The trust anticipates this increase to remain consistent.

The ED consists of a minors area with seating and five assessment/treatment rooms, a major area consisting of 16 cubicles and three side rooms, and a resuscitation area with four bays. The department also has a paediatric area with a waiting area and three cubicles. The ED corridor is also utilised to care for up to 10 patients who have been seen in the ED and are awaiting a bed in the hospital. At the upper end of the ED corridor there is an ambulance entrance, this area is used to care for ambulance patients when they cannot be handed over due to capacity.

There is an eight bedded observation ward adjoined to the ED, known as the clinical decisions unit.

During our inspection, we spoke to approximately 50 people and reviewed associated records of 38 patients. We also reviewed the trust's ED performance data. Urgent and emergency services provided by this trust were located on three hospital sites, the others being Alexandra Hospital and Kidderminster Hospital and Treatment Centre. Services at the other sites are included in separate reports. Services on all hospital sites were run by one urgent and emergency services management team. As such they were regarded within and reported upon by the trust as one service, with some staff working at all sites. For this reason it is inevitable there is some duplication contained in the three reports.

Urgent and emergency services

Summary of findings

We rated this service as inadequate because:

- Crowding and poor flow were having a significant impact on patient care and experience. The flow of patients in the emergency department (ED) was often blocked by internal capacity issues in the hospital. The trust was consistently not achieving the national target to admit or discharge 95% of patients within four hours of arrival. There was a lack of plans or strategies to correct this.
- There were not enough consultants to provide 16 hours of consultant cover within the ED each day.
- Due to patient care being carried out in corridors and small cubicles there was a lack of privacy and dignity for patients in these areas. Conversations could often be overheard and patients were expected to sleep overnight in these areas which were bright and noisy.
- The department did not meet the requirements of the national "Standards for children and young people in emergency care settings". Staffing did not always meet the necessary levels for paediatric care, and paediatric patients were often left alone with no observation.
- The arrangements for governance and performance management did not always operate effectively. Until November 2016, there had not been an effective governance framework to support good quality care for over a year. There was no clear process for the escalation of risks to divisional directors or the trust board.
- Infection control practices were not in line with trust policy or national guidance throughout the department.
- Staff did not feel valued or listened to by divisional and executive teams. This led to low morale and frustration amongst staff.

However:

- Incidents were reported appropriately and in-line with trust policy, even though some senior staff discouraged this. Staff knew what to report and how to report it on the electronic system.
- There was a strong team working ethos amongst staff in the ED, which most staff felt kept the department working in difficult circumstances.
- Patient feedback during our inspection was very positive about the nursing and medical staff that provided their care. Patients were treated with compassion and respect by staff throughout our inspection, despite the environment not supporting adequate dignity and privacy.
- Pharmacy provision was available seven days a week within the ED.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We rated safe as inadequate because:

- Staff were discouraged from reporting incidents relating to capacity and corridor care.
- Infection control practices were not always in line with trust policy, including incorrect utilisation of aprons and gloves. Items of equipment could also not be easily identified as being clean.
- Paediatric care within the ED was not always in line with national guidance. The paediatric area was also regularly left unobserved.
- The department did not have the physical space to meet the demand during times of poor flow out of the ED, resulting in patients being cared for in small cubicles and corridors.
- There was not a dedicated room to care for patients presenting with a mental health condition.
- Nursing staff had not completed level three paediatric safeguarding training that met national guidance. Child at risk registers were not always accessible in a timely way to ensure children were safeguarded from abuse.
- Consultant staffing did not meet national guidance of providing 16 hours presence each day.
- The clinical decisions unit was left without a registered nurse during break periods, leaving a healthcare assistant to care for up to eight patients.

However:

- All staff groups knew how to report incidents and what to report, and were reporting appropriately despite discouragement from some senior staff.
- Most staff had a good understanding of duty of candour and what this meant in practice.
- Nursing shifts were generally well filled, with plans to increase nursing figures to further meet patient needs.
- Senior nursing staff escalated patient and capacity risks where appropriate.
- Call bells had been installed into the corridor to mitigate risks where possible of caring for patients in this area.

Incidents

- There were no never events or serious incidents reported between October 2015 and September 2016.

  Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There were 1,237 incidents reported from October 2015 to September 2016. The majority of the incidents were categorised as no harm (79%). The most common themes related to tissue viability, medicines management and bed management/flow.
- The majority of incidents related to tissue viability/ pressure ulcers (50%). However, over 90% of these were present prior to hospital admission and therefore not attributable to the ED.
- All staff we spoke with knew what to report, and how to use the electronic reporting system. We observed several incidents being reported during the inspection and this was carried out in a timely way following the incident.
- There were some delays in the investigation of incidents. We observed that 22 incidents remained under investigation during our inspection. A number of these had been open for over 25 days; however, they had been allocated to a member of staff and had been viewed.
- Nursing leaders in the department told us that whilst themes from incidents were identified where possible, they did find difficulties in ensuring these were communicated well amongst staff. We observed that new display boards were present in staff areas of the department and leaders told us they hoped this would improve shared knowledge of incidents.
- Medical staff told us they had been discouraged by senior risk and governance staff from reporting incidents relating to capacity within the department as this was becoming a common occurrence. Medical staff felt that they should be reported to ensure an understanding of the risks in the department. We reviewed an incident relating to a patient receiving resuscitation in the middle of the resuscitation department, on an ambulance trolley due to lack of capacity. The trust risk team returned this to the member of staff advising them this was not an

appropriate incident to report and no lessons could be learnt from it. Another incident report contained comments from the trust risk team that they 'wonder the value and appropriateness' of incidents relating to patient harm from crowding in the ED. Also stating that as the situation is known they add no value. This created a risk that staff would stop reporting patient safety incidents and risks cannot be measured and mitigated appropriately.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.
- The majority of staff we spoke with could explain the importance of being open and honest with patients, and how this related to the duty of candour. However, two medical staff had no understanding of the duty of candour. We saw evidence for incident reporting that if something went wrong with a patients care, a senior member of staff had discussed this with the patient.
- The morbidity and mortality meetings were conducted quarterly for consultants to attend. Information following these meetings was then disseminated to other medical staff through their meetings.

Cleanliness, infection control and hygiene

- Infection control practices within the ED were not always in line with trust policy. We observed on several occasions staff not utilising gloves and aprons appropriate for patient care and cleaning tasks. On one occasion we saw a doctor drop their gloves on the floor then continue to put them on. Medical staff were also observed to answer phones and write notes with gloves on. We observed one doctor handling blood products in a syringe and not wearing gloves. The vast majority of nursing staff used gloves and aprons appropriately when administering medicines. Personal protective equipment (PPE), including gloves and apron were easily accessible throughout the ED.
- Staff did not always utilise alcohol gel when leaving or entering clinical areas, this included reception staff and domestic staff. Handwashing facilities and alcohol gel was available at regular points within the ED, we observed clinical staff washing hands between patient contact. However, there were no sinks within the corridor area where patients were continuously cared for. This meant that staff had to leave this area to go to the nearest sink located in the main nursing area or use staff toilet facilities.
- Stickers were available to allow staff to identify if an item of equipment was clean and suitable for use. We observed poor utilisation of these throughout our inspection; many clean items did not have green stickers on them for identification. Therefore, staff were using equipment without knowledge of whether it had been cleaned following previous patient contact.
- Patients who required isolation due to either infectious conditions or poor immunity were cared for in side rooms rather than curtained cubicles. We saw that doors remained shut at all times the patient required isolation and that there was a visible sign to inform staff and visitors that PPE was required before entering the room.
- The ED audited infection control practice in relation to hand hygiene, cleanliness of the department, wearing of PPE, aseptic technique and safe disposal of sharps. From April to August 2016 average compliance against standards was 88%. The most recent audit (July 2016) showed 87% compliance against the standards, with areas of non-compliance including, staff not utilising aprons correctly, poor hand hygiene and some cleaning rooms not being kept locked. The trust target was 100% compliance.
- The clinical decisions unit (CDU) carried out separate infection control audits to establish their area based compliance. From April to August 2016 average compliance against standards was 90%. Some areas of non-compliance occurred during each audit with no action taken, including fire doors being wedged open and stickers not being used to identify clean equipment.
- Audits had associated action plans where compliance was below the trust target, whilst we observed some of these actions were completed, other areas had not improved and there were no further plans to address areas of non-compliance.
- The department was visibly clean in most areas during our inspection. However, due to building work being carried out it was sometimes difficult for the department to remain fully clean and free from dust.

Domestic staff were called to areas as necessary where cleaning was required. We observed cleaning schedules in place and domestic staff could describe their responsibilities.

Environment and equipment

- At the time of our inspection extensive building works were being carried out to the ED. A minor injury area and a secure paediatric area had been added to the department and were both fully functional at the time of our inspection.
- The main waiting area was adequate for the number of patients at all times during our inspection. The waiting area could also be seen by reception staff. However, the physical distance between the main entrance door and the reception was limited. This meant if there were long queues patients would be standing in the door way and outside. Managers told us that to rectify this they would be implementing barriers to condense queuing and there had not been any complaints or incidents relating to this area.
- There were 16 cubicles within the majors area of the ED. However, four of these were previously seated cubicles and therefore, the curtain did not extend all the way around the trolley. The department had recognised that this area was unsuitable for patient care but had been challenged at a trust level to utilise this area for patient careThere were no plans to rectify this. Senior nursing and medical staff had escalated this concern to trust level but were advised that due to space shortages and demand they would have to continue to use this area.
- Severe crowding in the department meant that patients often had to wait on trolleys in a corridor. The corridor in question was narrow and quickly became congested making it difficult for staff and other patients to walk along the corridor.
- Paediatric patients often were advised to wait in the main waiting area with adult patients. Advice reception staff gave regarding this varied throughout our inspection. We observed some staff taking all paediatric patients around to the designated paediatric area; other staff asked paediatric patients to wait in the main area until after triage. National guidance states that paediatric patients should not wait with adult patients whilst in the ED.
- The new paediatric area had three cubicles and a seated waiting area with age relevant toys. The area met necessary guidance in relation to security. However, the waiting area had limited space and we observed parents standing and waiting with their children during peaks in demand. The dedicated children's waiting area could not always be observed by nursing staff which was not in line with national guidance, 'standards for emergency care settings for children and young people 2012', which recommends that nursing staff should be able to see patients at all times to identify a deteriorating patient. We observed periods of up to 20 minutes where the staff member in charge of the paediatric area was not present. Whilst there was CCTV in the area, this was not continuously monitored by any member of staff.
- We spoke with parents in this area who did not know what to do if they had a concern or worry and the nurse was not in the area. This meant that parents would have to leave the secure area and locate a member of staff if they had a concern. Cubicles had alarms and call bells present but these were also not accessible without swipe access. Once a relative left the paediatric area they would not be able to re-enter without a member of staff using their swipe card to gain entry. We were not assured that if a patient deteriorated this would be responded to in a timely way due to non-availability of staff.
- We escalated our concerns relating to the use of the paediatric area with nursing leaders who advised us they would take steps to rectify safety concerns. We were provided with information following inspection to show that signs had been put up in the area to show relatives how to raise an alarm if a child became unwell.
- Resuscitation equipment was available in all areas of the department, except the corridor. Staff within the corridor would have to enter the main area of ED to obtain equipment; staff knew where the nearest resuscitation trolley was and showed us this could be accessed in a timely way. Resuscitation trolleys were well maintained and checked regularly and had suitable equipment within them.
- We checked equipment in the ED and found that most equipment was serviced in line with manufacturer and trust requirements including electrical equipment testing. The trust provided us with evidence to show that there were systems and processes in place to ensure that equipment in ED was maintained.
- The ED door which ambulance patients were bought in through was being used as a shortcut for other staff. This was found during our previous inspection in 2015, and despite clear notices and the matron continuously

advising staff, this still occurred. This area was regularly used for holding ambulance patients and the doors opening unnecessarily for staff access meant privacy was impacted along with cold air entering into the area.

Medicines

- The trust had a comprehensive medicines management policy and auditing process which staff described to us during our inspection.
- Medicines were generally stored in line with trust medicines' management policy and fridge and room temperatures were regularly checked and temperatures recorded. Staff described what actions would be taken if medicines were stored at the incorrect temperature.
- Controlled drugs (CDs) were stored securely in designated areas with swipe or keypad access. Nursing staff were aware of Nursing and Midwifery Council standards for administration of controlled drugs and we saw that controlled drug records were completed appropriately.
- We found an unsecured box of medicines on a shelf in the store room that required returning to pharmacy. All staff, including domestic staff, had access to this store room which left the medicines at risk of tampering and theft. We discussed this with the matron who immediately arranged from them to be stored in a locked cupboard whilst waiting for pharmacy collection.
- On the new minors unit the refrigerator used to store medicines requiring cold storage had been recorded as being out of range on two separate days in November 2016. This was due to the refrigerator switch accidentally being switched off. Immediate action had been taken to ensure that medicines were still suitable for use and were replaced.
- Emergency medicines for resuscitation were stored on dedicated trolleys which were accessible and available for immediate use. There was evidence that they were checked regularly. However, some medicines including intravenous fluids stored on the resuscitation trolleys were not protected with a tamper evident label or seal to provide visible evidence that they were safe to use.
- Staff knew how to report a medicine incident and were able to describe recent examples of where they had done so.
- A seven day clinical pharmacy service operated in the ED. A clinical pharmacist monitored the prescribing of medicines and undertook medicine reconciliation. Medicines reconciliation is when a check is done to ensure that patients receive the correct medicines on admission to hospital. We observed the pharmacist counselling a patient about their antibiotic medicines, taking a drug history and confirming that the patient had the correct list of medicines prescribed.
- Emergency nurse practitioners could not tell us how they would access patient group directives (PGDs). PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions. Some staff believed there was a folder within the senior nurse's office but would not know how to access this if the room was locked. We reviewed PGDs which were available on the intranet and found them to all be in review date. However, there were concerns that staff did not know how to access these.
- There had been two time critical medicine incidents that were identified following an external review visit. Time critical medicines are those which require administration at specific times to prevent patients suffering from harm and must never be omitted. These incidents related to delays in Parkinson's disease and diabetes medicines being administered to patients whilst being cared for in the ED corridor. The pharmacy team were aware of this and were looking into how to prevent future occurrences.
- We reviewed 21 patients' records and found that allergies had been clearly documented in patient's records to minimise the risk of patients being administered an incorrect medicine.

Records

- There was a white board within the department that detailed patient names and their location. We found this to be kept up to date the majority of the time during our inspection. This allowed nursing and medical staff to have oversight of where patients were in the department and how much capacity there was for new patients. However, this board did not always document patients in the corridor, therefore we were not assured there was sufficient oversight of how many patients were being cared for in this area at all times.
- Patient records were not always managed and completed in a way that kept patients safe.
- Within the ED patient records were paper based, including all risk assessments. Whilst some risk assessments were already printed, some required completion on a computer then printing out. Risk

assessments were not consistently completed by nursing staff. We found cannula care assessments were not completed for seven patients records out of 14, dementia assessments were not completed for four out of five patients that met the criteria for requiring it. We found pressure area assessments completed for most patients requiring them, but they were not always completed in the same way and totals not always completed.

- Nursing and medical notes were not always kept together, especially for patients being cared for in the corridor. This meant that staff did not always have full oversight of each patient's condition and care plan.
- There were instances during our inspection where patient records could not be located. We requested to view one patient's record that was being cared for in the corridor, it took several staff to find where they were located and meant they were not accessible in a timely way.
- Patient identification stickers were not always placed onto all paperwork and risk assessment relating to their care. This meant that if they became loose or fell out of a folder they would not be able to be identified to the patient they were associated with.

Safeguarding

- There were systems and processes in place to ensure that patients were safe from abuse. However, we were not assured that all staff had the appropriate level of training to ensure they could recognise abuse.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health 2014, states that 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three.
- Nursing staff had not received the appropriate level three safeguarding training. Training was done online, with no face to face aspect meaning it did not meet guidance. This was being address by the department and all staff were booked on to complete a level three course by the end of 2017. Level two adult and paediatric safeguarding training had been completed by 89.4% of nursing staff.
- All medical staff had completed safeguarding level three safeguarding children training and demonstrated a good knowledge of recognising and reporting concerns.
- All children were checked against the child protection register. This information was contained in a book within the triage room and was updated monthly. However, we observed that on occasion, the triage room was in use and therefore the book was not always accessible in a timely way.
- A paediatric liaison nurse visited the department four days a week to review paediatric attendances and provided a link to school nurses and health visitors.
- There were visible notices relating to domestic violence and how to report concerns. We also spoke with several nursing staff that had a good knowledge of this subject and what to do if they suspected a patient or relative was at risk of domestic abuse.
- Staff had not received any training in child exploitation or female genital mutilation. The new safeguarding lead had plans to include these topics in future training to raise awareness.

Mandatory training

- Mandatory training attendance did not meet trust targets for some subjects, including equality and diversity (63%), infection control (85%), and fire safety (85%). However, 100% of staff had completed information governance training and 93% had completed manual handling training.
- Staff had two weeks of protected training time each year, during these two weeks mandatory training was undertaken.
- All medical staff had completed advanced life support training. Basic life support training had been completed by 88% of nursing staff. We were not provided with data for nurse training relating to advanced/intermediate life support training.

Assessing and responding to patient risk

- Patients who self-presented to ED were required to report to the main ED reception. Protocol was for any paediatric patients (under the age of 18) to be directed to the paediatric area. This did not always occur during our inspection.

- The receptionist directed adult patients to the waiting area, unless they felt the patient looked severely unwell in which case they would go and speak to the triage nurse immediately. Reception staff told us they had a list of symptoms, including chest pain, signs of a stroke and difficulty in breathing, that they would escalate concerns immediately to the triage nurse.
- Patients within the waiting area were then seen by the triage nurse; this was for an initial brief assessment to establish how urgently they required treatment/further assessment. Patients were seen in chronological order, unless the receptionist had flagged them as having life threatening symptoms. We observed triage processes to be in line with guidance. However, doors between the triage room and reception were often left open, which meant triage could be overheard by other staff.
- Patients attending EDs should receive triage within 15 minutes of their arrival, in line with national targets. Due to conditions imposed by the CQC following our previous inspection, the ED was required to report its adherence to this target. From April to September 2016, 3,958 patients (13%) were not triaged within 15 minutes of their arrival in the department out of a total of 30,683 attendances. Out of those 3,958, 678 (2% of total patients) waited over 30 minutes for triage. The main reasons given for delays in triage across these months were; capacity, surges in demand and delays by triage nurse. There were no cases of patient harm reported within this timeframe.
- Following triage patients were either directed to the majors area, to minor injuries, or asked to remain in the waiting area. There was always one designated triage nurse within the department, if there was a surge in demand an emergency nurse practitioner (ENP) from minor injuries would assist to maintain flow. All areas of the waiting area and minors could be observed by staff, who were all aware how to obtain help if a patient deteriorated or collapsed.
- Within the majors area, the majority of cubicles could be observed from the nursing station. All patients had call bells available and knew what to do if they required assistance. We did not observe any significant delays in call bells being answered during our inspection.
- Corridor care was carried out in the department, which involved up to 10 patients being cared for on ED trolleys within an adjoining corridor. All patients cared for within the corridor had been triaged, assessed, had diagnostics and then referred to a specialty/ward. These patients could not be moved to the necessary areas due to problems with flow throughout the rest of the hospital. We were informed there was a criterion for patients to be cared for in this area, including that the patients National Early Warning Score (NEWS) had to be below five. However, throughout our inspection we saw patients who did not meet the criteria being cared for within the corridor due to acuity of other patients requiring ED cubicles. We also observed on occasion that up to 12 patients would be cared for within the corridor which was above the limit within trust policy. Senior nursing and medical staff advised us that this occurred due to the need for higher acuity patients within the majors department of the ED. We were told this was judged on a case by case basis to ensure patients were in the most appropriate area for their medical needs. The ED had installed call bells into each trolley area within the corridor, as there had been previous concerns that patients cared for in this area would not be able to call for assistance. Senior nursing staff advised that they escalated when the corridor reached its maximum limit but did not see further action occurring from a trust level to reduce this number of patients in the corridor area.
- The department completed regular safety matrix checks to establish which escalation level they met. Throughout our inspection the ED was either red or black, meaning it was classed as overwhelmed. Senior nursing staff reported this to the site teams every two hours. However, the senior nurse in charge and the matron were not always informed of what was escalated further after this point. We observed the ED escalating capacity concerns throughout our inspection and minimal action was taken at trust level to improve flow.
- Patients arriving in the department by ambulance were handed over to a senior initial assessment nurse (SIAN). The role of the SIAN was to provide a timely initial assessment to ambulance patients and ensure turnaround of ambulance crews did not affect waiting 999 calls. Each shift there were either one or two SIANs to cover ambulance patients, we observed this flexed according to demand. SIANs could care for up to four patients within an upper corridor area of the ED. We witnessed a patient experience a seizure whilst being cared for in this area. The nurse caring for the patient had to leave the patient unattended to request help from the nursing station. We escalated the lack of

facilities to raise alarm in the area during our inspection. To mitigate this risk the ED put an alarm in the upper corridor area to allow ambulance crews and staff to request help if a patient became critically unwell.

- We observed periods of time where the SIAN was at full capacity and could not take any more ambulance patients under their care. Once this occurred, ambulance crews had to remain with their patients in the upper corridor area. A hospital ambulance liaison officer (HALO) was on site at all times to facilitate flow of ambulance patients and provide a link role between the ambulance service and the hospital. We were told that the HALO should not take handover or clinical care of any patients as this impacted on their liaison role. However, during times of significant demand, we saw this occur to allow ambulances to respond to 999 calls.
- From October 2015 to September 2016, there had been 535 black breaches. A black breach occurs when ambulance handovers to ED exceed 60 minutes. The department were working with the ambulance service to reduce delays in turnaround times.
- Following our previous inspection, conditions were imposed on the trust that required them to report on time to initial assessment within the ED on a weekly basis.
- Within this report, harm assessments were carried out on patients who had delayed initial assessments within the department. From May to September 2016 no harm had been identified of any of the patients relating to a delay in initial assessment.Themes/issues within patient care for this group of patient was also assessed, with the most common areas being; skin maps not completed or not done within 30 minutes of arrival, transfer forms not used robustly, blood glucose not assessed and insufficient care and comfort entries for length of time in department.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for the entire 12 month period from August 2015 to July 2016. During this time frame performance against this standard was between 35 and 45 minutes. In July 2016 the median time to treatment was 48 minutes compared to the England average of 61 minutes.
- The CDU could care for up to eight patients. Patients in this area were required to meet criteria to ensure suitability.
- If a patient required diagnostics, such as x-ray or computerised tomography (CT) scan, they would either be escorted by a porter or by nursing staff. An appropriate policy was in place to advise staff under which situations a nurse escort would be required to ensure patients safety.
- A NEWS was used in adults ED and a paediatric early warning system (PEWS) was used for paediatric patients in line with the National Institute for Health and Care Excellence (NICE) guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). We reviewed 32 sets of records and found that 30 had a NEWS completed on their initial assessment. As part of a trust wide mortality review, a NEWS action plan was in place to ensure a reduction in avoidable deaths. Staff training in relation to NEWS had been identified within this action plan as an area that required improvement. Due to only recently changing to using NEWS to measure patient acuity, audits had not yet been conducted to establish compliance with utilisation. The department itself did not carry out NEWS audits to establish if correct escalation processes were followed.
- The ED used Sepsis Six (this is six steps to managing patients suspected of having severe sepsis, neutropenic sepsis or sepsis shock). We looked at seven sets of records where patients had been identified as potentially having sepsis; we found that completion of the sepsis bundle was inconsistent across these records. Whilst the majority of patients received antibiotics within the required one hour timeframe, areas such as fluid balances and intravenous fluid administration were not completed for three out of the seven patients.
- Dementia and elderly care assessments were required to be completed for all patients attending the ED over the age of 75. We reviewed 11 sets of notes of patients over 75 years and found these were not both completed for eight patients (73%).

Nursing staffing

- Nurse staffing levels within the department did not always meet national guidance.
- There were 3.5 whole time equivalent (WTE) registered nurses (RN) (children's branch) working within the ED. This was not sufficient to ensure that there was at least one RN (children's branch) on duty 24 hours a day in line with Royal College of Nursing (RCN) guidelines 'Defining staffing levels standards for children and young people

services, RCN, 2013'. The trust told us they mitigated this by providing nine adult RNs with additional paediatric training at a local university to ensure competence in paediatric monitoring and assessment. We observed that between October and November 2016 there were three shifts with no nursing staff with paediatric competencies working in the ED. Senior staff told us that their ideal situation would be to share staff with the paediatric wards of the hospital, allowing staff to rotate between the ED and other wards. Recruitment plans were in place to acquire further children's branch RNs. This meant that children were not always cared for by nurses with the appropriate qualifications or competencies to treat or assess them.

- During day shifts 13 nursing shifts were allocated, this reduced to 12 for night shifts. The department employed 90 WTE RNs during our inspection. These figures allowed for two RNs to be allocated to the corridor for each shift.
- From May to August 2016 the average fill rates for nursing shifts was 95.2%. Average fill rates for healthcare assistants during this period was 96.6%. Senior staff told us that where necessary bank staff or regular agency staff would fill vacant shifts. We observed an induction folder was in use for agency staff to ensure their competencies for working within the ED.
- The CDU was staffed by one RN and one healthcare assistant (HCA) during our inspection. This was not in line with the CDU policy which stated it should be staffed by two RNs and one HCA. We also observed that whilst the RN was taking their break, the CDU was left being overseen by the HCA with no registered nursing support. We were advised this was regular practice due to lack of staff to cover the department during break.
- The department employed 3.5 WTE emergency nurse practitioners (ENPs) to oversee the minor injury area of the ED. There were plans in place to increase ENP numbers to improve flow through minor injuries.
- We observed 35 incidents specifically relating to lack of available suitable staff from September 2015 to October 2016. These had all resulted in minor or no harm to patients.

Medical staffing

- The ED had on-site consultant cover Monday to Friday 8am to 11pm, and 8am to 6pm Saturday and Sunday. Outside of these hours the team was led by a specialist registrar (SpR) who had access to an on-call consultant. This did not meet the Royal College of Emergency Medicine recommendations to provide 16 hours of consultant presence.
- At the time of our inspection the ED had 4.7 WTE consultants (1 WTE locum) with 1 WTE consultant starting in January 2017. Following this recruitment there were 4.3 WTE vacant positions. We were told that the trust was having difficulty recruiting to these positions due to significant pressures within the ED.
- All consultants were working one in every eight weekends and one in every five night shifts.
- There were 4 WTE middle grade (ST4+) doctors working within the ED on a nine person rota. This meant a reliance on locum and SpRs to cover extra shifts.
- Night time cover was provided by one SpR and two senior house officers (SHOs). The department had recognised that the number of four hour breaches increased at night time and had submitted plans for an additional SHO.
- National guidelines for EDs treating more than 16,000+ children a year state that there should be at least one consultant with sub-specialist training in children's emergency medicine. Whilst the department did not meet this number of attendances, there were two consultants who had this training. Due to the Alexandra Hospital no longer providing paediatric services, the ED anticipated an increased in paediatric attendances which may then mean they meet the 16,000 patient threshold.
- The department used locum doctors to cover vacancies. The trust provided induction for locum staff and we observed one locum doctor being orientated to the ED. Where possible the ED utilised regular locum doctors who were familiar with the processes and procedures within the department.
- We observed effective medical handovers and saw that doctors discussed the acuity levels of the patients in the department and any issues or concerns highlighted from the shift.

Major incident awareness and training

- The trust had an up to date major incident policy in place.
- The ED had a departmental major incident plan which included action cards to describe the roles and responsibilities of individual members of staff. A member of the nursing team undertook a link role in

relation to major incidents and training provided. We were informed that exercises occurred but these were not always timely due to demand within the department. The staff did not have a record on when the last exercise had happened. Not all staff were familiar with the policy and had not undertaken specific training or completed any exercises.

- There were two major incident cupboards within the ED; one contained gowning equipment, the other a general store. The general store contained a significant amount of equipment, including airways, dressings and PPE, that was past its expiration date by up to 12 years. We were told that this cupboard was not used at the time and action would be taken to ensure that all out of date equipment was removed. We saw staff beginning to address this at the end of our announced inspection.
- The department had plans in place and access to equipment to manage individual patients who had been exposed to chemical, biological, radiological or nuclear (CBRN) agents. There was also a dedicated room to provide care for the patients that met guidance.
- Staff in ED had access to on-site security services, reception staff told us that they were accessible and attended the department in a timely manner. If necessary the police were called where security were unavailable or unable to resolve a situation. We observed security staff managing an incident and this was dealt with well and had a successful resolution.
- Staff in the main walk-in reception area had access to a panic button. However, they had not been advised how to use this or what response would be received.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- There were not always written policies or procedures to support staff in the minor injuries area.
- Pain relief was not always provided in a timely way.
- Medical staff felt that interaction with some of the hospitals other medical teams could be improved to improve patient care.
- There were not physiotherapy and occupational therapy services within the ED, these were provided on referral.
- Staff knowledge of Deprivation of Liberty Safeguards (DoLS) was not always sufficient and instances of patients being deprived without requests for DoLS being made occurred.

However:

- Medical staff conducted local audits to improve patient outcomes.
- Clinical guidance in the department met national guidance.
- Newly qualified staff were well supported in the department.
- Staff felt multidisciplinary working was productive and teams supported each other.
- There was a dedicated pharmacy team which provided seven day support to the ED.
- Staff were provided with protected training time to ensure their training needs were met.

Evidence-based care and treatment

- We saw evidence that care was generally delivered in line with recommended national guidance for EDs and medicine. This included specific pathways for patients presenting with head injuries, sepsis and fractured neck of femur.
- We saw that the department had a clinical audit programme which included audits based on Royal College of Emergency Medicine (RCEM) and National Institute for Health and Care Excellence (NICE) guidelines.
- The department used the 'sepsis six' care bundle in line with NICE guidelines for adults and children. This pathway enables the rapid recognition and treatment of sepsis in line with guidance. We saw that the department was taking part in a CQUIN (Commissioning for Quality Innovation frameworks) audit related to sepsis. The most recent data showed 66% compliance with the CQUIN which did not meet the target of 90%. Low compliance was generally related to delays in assessments. Senior staff told us they were aware of areas where sepsis care required improvement and that work had begun to improve awareness and completion of the all areas of the departments sepsis bundle.
- Local audits were conducted within the department to ensure compliance with evidence based practice, including head injury, venous thromboembolism (VTE)

risk in lower limb immobilisation and management of renal colic pain. Action plans were implemented where areas of non-compliance with national guidance was identified.
- Emergency nurse practitioners (ENPs) demonstrated they understood evidence based practice and followed this when treating patients. However, there were not written policies or procedures in relation to managing minor injuries within the department to support this.

Pain relief

- The ED used pain scores for both adults and paediatric patients. These were either a score of zero to 10, or using a range of smiley to sad faces. We reviewed 18 sets of records and found that whilst an initial pain score was recorded by a triage nurse, these were not consistently reviewed and there were often delays in the prescription and administration of analgesia.
- Delays in pain relief were increased for patients that were cared for in the ED corridor. We were asked by patients on a number of occasions if they could have some further analgesia, we informed the nurse who was caring for them on each occasion this occurred. Nursing staff in the corridor felt that delays could sometimes occur if they were assisting patients with personal care which sometimes was prolonged and required both nurses to assist.
- In the CQC Accident and Emergency Survey 2014, the trust scored 6.6 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts. The trust scored 7.8 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Nutrition and hydration

- Due to the delays in transfer to wards patients were often requiring two to three of their meals a day to be eaten within the ED. We observed that patients in the corridor had a sign to advise staff whether they were nil by mouth. This had begun due to patients in the corridor waiting for long periods without food or drink due to staff being unsure of their status. Staff advised us they could generally only provide sandwiches in the corridor which meant that patients could go a prolonged period of time without a hot meal.
- Comfort rounds had been implemented within the department and these documented when patients had last has something to eat or drink.
- We observed that patients who had urinary catheters fitted had their intake and output documented in their records regularly.

Patient outcomes

- In the RCEM 2013/14 audit published in September 2014 of severe sepsis and septic shock, all indicators scored in the upper national quartile, demonstrating positive outcomes. These included the measurement of blood cultures, administration of intravenous crystalloid fluids and antibiotics. There was an action plan in place following the audit that had two actions on it. One was to use the sepsis proformas better. To achieve this, the plan was to provide weekly updates and training to nurses, we saw evidence of this being completed. The other action was to re-audit in 12 months. This had not been completed.
- In the RCEMs 2013/14 asthma in children audit, most indicators scored in the upper national quartile, signifying positive outcomes. These included initial observations and subsequent observations following beta 2 agonist administration. One indicator scored in the lower England quartile, which was the non-administration of beta 2 agonist given by spacer or nebuliser. There was no audit action plan in response to the audit of asthma in children.
- In the RCEMs 2013/14 paracetamol overdose audit most indicators scored between upper and lower England quartiles. Two indicators scored in the lower quartile, indication worse than the average outcomes. These included in all cases decline of treatment and where dose exceeded 6g and was over eight hours since ingestion. The audit showed the hospital scored better than the average for patients receiving N-acetylcysteine (NAC) within eight hours of ingestion. No action plan was submitted in relation to ED at Worcestershire Royal Hospital in response to the audit.
- The RCEMs initial management of the fitting child audit 2014/15 showed that the ED met standards of the management of active seizures and recording clinical information. The ED did not meet the standard for checking and documenting blood glucose; and providing written safety information to patients and/or

carers. There was an action plan following the audit which included feedback to the department to record a blood sugar. However, the action plan did not address the lack of safety information provided.
- The department was not meeting the standard that requires the percentage of patients re-attending (unplanned) the ED within seven days to be less than 5%. From October 2015 to November 2016 the trust's unplanned re-attendance rate within seven days was 6.7%, worse than the national standard of 5%.
- In the RCEM's 2014/15 ED mental health audit showed that the ED was in the upper quartile of results, indicating better outcomes compared to other audited EDs. This included patients receiving a mental state examination. However, results did not always meet RCEM standards, despite being better than other audited EDs. For example, patients receiving a risk assessment which was recorded in the clinical record was 96%, better than the audit median of 97% but did not meet the target of 100%. An action plan was in place to improve areas that did not meet the target.
- All middle grade doctors were required to carry out an audit every quarter whilst working within the ED. All middle grade doctors we spoke with had been completing audits and were linking them to patient outcomes. Once audits were completed they were presented at teaching sessions with the associated patient outcomes.

Competent staff

- Within the ED 84% of nursing staff had received an appraisal in the previous 12 months.
- Revalidation is the new process introduced in April 2016 that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council and allow them to continue practising. The department was working with a practice development lead to assist staff through this process.
- Newly qualified nurses were given protected time as a supernumerary member of staff for up to four weeks. This allowed them to become confident with the working practices of the ED and work closely with other nursing staff for support.
- All staff were allocated two weeks training time per year. In these weeks mandatory training would be completed, along with any other modules for new clinical care or guidance.
- Staff were provided opportunities to attend courses at local universities where they had an interest. This included a course to develop paediatric assessment and treatment competencies, which nine staff had completed.
- ENPs worked at both the ED and the minor injury unit at Kidderminster Hospital and Treatment Centre, this enabled them to see a varied range of presenting complaints, and maintain their skills.
- Medical staff told us they were given protected time for training days and that they were well supported through any developmental needs and training.

Multidisciplinary working

- Working relationships across multidisciplinary teams was generally productive within the ED. Staff described good working relationships with staff from the medical admissions areas but felt that it was not so good with other specialties.
- We observed allied health professionals working well in the department and discussing patients with ED staff to ensure a holistic approach to their care.
- There was a GP from an external provider working within the ED. Staff told us that they had good working relationships with the GP and they were able to provide care to patients who presented with minor illnesses.
- The ambulance service worked closely with the ED, with a hospital ambulance liaison officer (HALO) working within the ED. The HALO enabled open communication between the ED and the ambulance service to ensure timely resolution of any concerns or problems. Ambulance staff and HALOs spoke highly of the nursing and medical staff in the department.
- The ED had access to a mental health liaison team and described good working relationships with this team. Staff could also access child and adolescent mental health services for paediatric patients. Staff described that there were sometimes significant delays in child and adolescent mental health service attending the department to see patient and that adult mental health provision was much timelier.

Seven-day services

- The ED was open to adult and paediatric patients 24 hours a day seven days a week.
- The department had dedicated x-ray facilities which were staffed by radiology teams and available 24 hours a day, seven days a week.

- There were no dedicated ED physiotherapists or occupational therapists. Staff could access physiotherapy staff via referral Monday to Friday from 7am to 7pm. Occupational therapists could only be accessed if the patient was being cared for within CDU.
- The ED had a dedicated pharmacy team who provided a seven day clinical service.
- The ED had access to an emergency and trauma theatre as per national guidance 24 hours a day, seven days a week.
- Mental health and alcohol liaison teams worked within the department. These services were available until 8pm. If a patient required referral to these teams out of hours, they would stay in the department overnight until the teams began in the morning.

Access to information

- All staff could access clinical guidelines, policies and pathways via the trust intranet.
- Whilst all patient records were paper based, the ED used an IT system that allowed patient tracking so that all patients could be identified by area and also their time in the department. Staff could also use this system to establish capacity and activity across other EDs within the trust.
- Staff told us they could easily access diagnostic and radiology results in a timely way.
- Patient records were taken to the admitting ward with them. We observed staff carry out checks to ensure they were ready prior to transfer of the patients.
- Patient discharge summaries were sent to GPs once they were discharged from the department to enable them to be aware of the patients presenting complaint and any treatment they received.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff within the ED demonstrated a good knowledge of consent and Mental Capacity Act 2005 (MCA) and how this related to their practice.
- Nursing staff did not complete MCA assessments, we were told that these would be completed by medical staff where required.
- Not all nursing staff understood Deprivation of Liberty Safeguards (DoLS) and when these would be required.
- We observed two patients being cared for in the ED that had bed rails placed upon their bed, and they were prevented from leaving their bed on numerous occasions. These patients had not received a mental capacity assessment, and a DoLS had not been put in place. We discussed both these patients with nursing staff, and whilst it was in the patient's best interest due to their medical condition, trust policy had not been followed. Both of these patients were reviewed following our escalation. Senior nursing staff told us previously DoLS would not be required in ED due to the minimal amount of time patients should spend in the department. However, due to crowding within the ED and patients spending prolonged periods of time in the department it was more likely patients would be cared for that required DoLS or best interest decisions.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Staff consistently showed compassion and emotional understanding throughout their interactions with patients.
- All staff took the time to speak to patients and relatives if they had concerns or worries.
- Services were available to support patients and those close to them in last days of life or following bereavement.
- Patients spoke very highly of the staff caring for them and felt they were kind and considerate.

However:

- Patient dignity and privacy was often not maintained due to patient care being carried out within corridor and unsuitable cubicles.

Compassionate care

- Patients and those close to them were treated compassionately and with respect throughout their care in the department. Nursing staff worked exceptionally hard to ensure patients were comfortable and provided with the care they required.
- We observed staff taking the time to interact with patients, relatives and those accompanying them in a

caring manner. Staff took the time to apologise for any situations where a patient's privacy was not maintained and patients told us they appreciated being spoken to about this.

- Patients we spoke with told us that the staff 'do an amazing job in an extremely difficult situation' and that they 'go above and beyond'.
- The NHS Friends and Family Test results for May 2016 to October 2016 showed that an average of 59.2% of patients would recommend the service. The trust target for this was 70%. Response rates varied during this time period, averaging at 8.4%, against a target of 20%. Comments received with this feedback mentioned friendly and polite staff, but waiting times were too long and corridor care was unsatisfactory.
- Privacy was also a problem in four cubicles in the majors area. These four cubicles were originally designed to be seated areas; they were being used permanently as trolley spaces during our inspection. Due to the design, the curtain rails did not extend far enough outwards to allow patients lower limbs to fit inside. This meant that curtains were left open the vast majority of the time.
- We observed that there were substantial difficulties in maintaining patient's dignity due to space and facilities. We observed all medical and nursing staff doing their best to provide compassionate and considerate care in this circumstance. Where dignity could not be maintained staff showed an awareness of this and mitigated it where possible.

Understanding and involvement of patients and those close to them

- Patients that we spoke to told us that they had felt involved with their care and understood the treatment they were receiving.
- Staff recognised when patients and those accompanying them needed additional support to help them understand their care and treatment; this included access to translation services. We observed staff changing their communication styles and speaking slower for patients who appeared to have difficulty understanding what was being said.
- We saw that staff directed patients, carers and relatives to access information about their care and treatment from the information leaflets throughout the ED.

Emotional support

- There was a multi-faith chaplaincy service available on site to patients and visitors who required it. Bereavement services were accessible and the bereavement service provided by the midwifery team offered support to the ED in the event of a paediatric death.
- The palliative care team visited the ED daily to establish if they could assist any patients or relatives who were in the last few days of life. Feedback regarding this service was positive.
- We observed staff showing genuine concern for patients and relatives who were distressed or anxious. Nurses held the hands of elderly patients to comfort them when they became upset.

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

Inadequate

We rated responsive as inadequate because:

- There were significant problems with crowding and accessing beds in admitting ward in the department, with no clear trust level plans to correct this.
- Patients were routinely cared for within the ED corridor following a decision to admit being made.
- The department was not consistently meeting national targets for service delivery.
- There were no clear plans in place to improve flow within the ED.
- There was a lack of ownership by other areas of the trust in relation to flow and the four hour target.
- The department did not have clear pathways in place to support patients with complex needs, such as a learning disability and patients living with dementia.
- The CDU was not being utilised in line with trust policy and patients were staying in the area for in excess of 72 hours.

However:

- The department had worked with external providers to improve the minor injury and illness services. GP provision was available to patients to ensure patients saw the right practitioner and avoid all patients having to be seen within the main ED pathway.

- All senior nursing and medical staff showed a thorough understanding of the flow issues within the ED and had clear ideas of how they would improve this.
- Plans were in place to improve dementia care and link staff in the near future.
- Paediatric areas were suitable and contained bright decorations and toys to improve patient experience for younger children.

Service planning and delivery to meet the needs of local people

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external providers and this had resulted in GP's practicing within the minor injury area of the ED to support the department. This was in line with Royal College of Emergency Medicine (RCEM) guidance on how to achieve safe, sustainable care in EDs.
- Senior managers within the ED recognised that the facilities were not adequate to meet the needs of the local people and were currently expanding the environment. However, managers were concerned that whilst this would meet the number of attendances to the ED, if the delays in flow continued this would not fully meet the needs of the local population.
- We saw that information regarding the local population and changes in attendance numbers had informed changes in staffing figures, including an increased in adult nursing posts over the last year.
- There had been a recent reconfiguration of paediatric services within the trust. This meant that all paediatric ED patients now attended Worcestershire Royal Hospital. Prior to reconfiguration, paediatric patients could also attend the neighbouring ED at the Alexandra Hospital. There had been minimal changes in paediatric capacity and staffing since the reconfiguration of services. There were no plans in place to rectify this to meet the needs of those attending the department.
- We saw that the department was working with the local ambulance NHS trust to develop pathways of care and working practices to improve ambulance handover times and ensure that patients were at the right point of care.

Meeting people's individual needs

- We observed that there were substantial difficulties in maintaining patients' dignity due to space and facilities. The main area this was problematic was in the ED corridor. Patients were often cared for here for prolonged periods of time (in excess of 12 hours) on a trolley with in excess of 10 other patients. Trolleys were extremely close together and screens were not used to provide any privacy. All conversations could be overheard, including those relating to a patient's clinical condition and care. All nursing staff we spoke with showed a clear understanding of the impact of this, and were doing the best they could to provide care in a substandard situation. Medical staff felt strongly that corridor care impacted on patients' privacy and would on occasion delay discussions to avoid confidential information being overheard. Whilst corridor care was on the risk register there was no information relating to patient dignity contained within this risk.
- There were no toilet facilities for patients in the corridor area. Those that required assistance would be taken to the plaster room to use a commode by the nurses covering the corridor area. If this room was in use they would have to wait for a cubicle or the room to become free. If patients were mobile, they were asked to go across the department to use patient toilets located in the majors area.
- We saw that staff responded quickly to patient requests for toilet facilities, drinks and repositioning.
- The department did not have a clear pathway for caring for patients with a learning disability or dementia. There was no flagging system to identify patients with a learning disability who had previously attended the department. There was no identification system to ensure staff working in the department knew which patients had additional needs, communication difficulties or living with dementia.
- Nursing leaders told us they were aware improvements were required in this area and that there were staff that had showed an interest in developing distraction tools and decorating areas to meet needs of these patient groups. Plans were in place to paint rooms yellow and provide clocks more appropriate for patients living with dementia; however, this had not been implemented at the time of our inspection but was due to be completed within six months.
- We observed patients living with dementia and those with complex social needs being cared for within the

corridor area. This environment was not suitable for these groups of patients due to the area being extremely busy, staff and visitors walking through and loud noise levels.

- Face to face and telephone translation services were available where needed in the department. Staff we spoke with knew how to access these services.
- There was a relative's room within the department that was used for breaking bad news to families and also following bereavements. This had a kettle and sofas available for relatives.
- A bereavement midwife would visit the ED in the event of a paediatric death, they provided support and advice to families and debriefed staff.
- We saw a range of advice leaflets within the ED, some of these had advice in alternate languages. However, staff were unsure how to access full leaflets in an alternate language.
- Within the paediatric area there were bright decorations and toys available. However, these were mainly aimed at very young children. Nursing leaders told us of plans to make an opposite corner focused more on teenagers. Families we spoke with felt the environment was responsive to their child's needs and liked the brightness of the area.
- Within the main waiting area there was a whiteboard that displayed current waiting times; we found that this was not always up to date. There was no designated member of staff responsible for updating this board.
- Refreshments were available to patients waiting within the ED. Sandwiches and hot drinks were provided to patients who had been within the ED for extended periods and we observed patients and relatives being offered this regularly.

Access and flow

- Crowding was a significant issue within the adult ED. Crowding is when ambulances cannot transfer patients to the care of the hospital. There were long delays for unwell patients to see a doctor, patients on trolleys in the ED exceeded cubicle spaces and patients were waiting for more than two hours for an inpatient bed after a decision to admit had been made.
- The RCEM 'Crowding in the Emergency Department 2012 (revised 2014)' recommends that EDs should have a hospital wide escalation policy to manage overcrowding in the ED. We found escalation policies in the trust to be unclear and the site team were not always clear on what steps should or had been taken during times of increased demand in the ED. The ED completed two hourly safety matrixes to advise the trust on their capacity. Alongside this, the trust as a whole followed two processes of escalation, one was described as being an ambulance based escalation. We were advised the trust normally sat at level three escalation, and that it was 'almost impossible' to reach level four escalation, due to some triggers, which would then result in stronger actions. This meant the ED was continuously over capacity and caring for patients in the corridor without full escalation occurring.
- The second escalation process the trust followed was a full capacity protocol which should be implemented once the trust either reached level four escalation or the ED showed as 'overwhelmed' on their safety matrix, along with other triggers relating to capacity. This protocol stated it could only be implemented between 9am and 7pm. We were advised by the site team and senior executives that this had never been implemented previously despite meeting the criteria for implementation on days of our inspection. We were advised that out of hours, if the hospital reached full capacity, nothing could be done until the following morning.
- The Department of Health target for EDs is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. From August 2015 to July 2016 the ED did not meet the target, with an average of 79%. We saw that there was no improvement on performance, with the ED only achieving above 70% for one month since February 2016. Senior staff told us that flow out of the department had a knock on effect of patients attending the department and the time taken to make a decision relation to their care.
- From April to October 2016, 36.7% of patients waited between four to 12 hours to be admitted following a decision being made about their care. Throughout our inspection we saw patients regularly waiting over 12 hours for an inpatient bed after a decision to admit, and some of these patients waiting 22 hours in the ED corridor due to lack of hospital beds. Senior doctors told us of two instances where patients deteriorated whilst being cared for in the corridor, and had subsequently died. The trust told us that their investigations into these incidents found that whilst being cared for a period of time in the ED corridor area was not ideal, this had not had any impact on the patients' deaths.

- From April 2015 to March 2016, 312 patients waited in the department for longer than 12 hours following a decision to admit them to a ward.
- Best practice in crowded EDs is to reverse queue patients. This means that rather than holding ambulances in a corridor, patients that are ready to go to wards are cared for in another clinical areas to allow ambulance patient handovers. This is based on ambulance patients being more at risk due to not having been reviewed by a doctor and having only received pre-hospital care.
- Corridor care (reverse queuing) had become normalised within the department by the trust and there were regularly 10 patients being cared for on an ED trolley in the corridor. Call bells had been fitted to corridor spaces and plans were in place to fit electrical sockets so that care could continue in this area. Medical and nursing staff described this as their main concern and worry about care within the ED.
- Each patient being cared for within the corridor was provided with an explanatory letter telling them why they were being looked after in the ED corridor and apologising for this. Most people we spoke with felt this was helpful and provided them with the necessary information.
- A significant number of medical and nursing staff raised concerns with us around corridor care in the ED and how they felt the trust did not consider this a high enough risk. Staff were extremely frustrated with providing care in the corridor and showed a clear understanding of how this impacted on not only clinical care, but patient experience. There had been numerous incidents reported in relation to corridor care, both relating to clinical deterioration and unsuitability.
- We observed the department at full capacity throughout our inspection, which meant that if a patient required a resuscitation bed, then patients required moving around the department. We witnessed this on three occasions and despite shortages of space, staff worked well together to ensure the right patients were in an appropriate area of the department.
- Volunteers regularly assisted in the department to help provide basic care, such as food and drinks for patients, mainly in the corridor.
- Following a reconfiguration of services, paediatric patients were now only seen at Worcestershire Royal Hospital and no longer at Alexandra Hospital. This had caused an increase in paediatric ED attendances by around 18%. At the time of our inspection, there were not enough outcome evidence to establish what impact the increase had had on patient care.
- The clinical decisions unit (CDU) had a capacity to care for up to eight patients on trolleys. There was a policy in place for use of this area and also associated criteria which stated which patients could be cared for in this area. We found during our inspection that two main criteria were routinely not followed in relation to patients within this area, which were: the maximum length of stay being 24 hours and all patients admitted to the CDU must have a management plan including reason for admission, relevant investigations and discharge plans. We observed five patients who had been on the CDU for over 24 hours; two of these had been on the CDU for over 72 hours. We also observed that whilst most had management plans in place, they did not all have associated discharge plans.
- From April to October 2016, 2.8% of patients left the department before being seen. This was better than the national target of 5%. The department monitored this data and if it rose to above 5% action plans would be put in place; however, this had not occurred previously.
- We observed that the department went on peripheral and full ambulance diverts on three occasions during our inspection. This results in patients being taken by ambulance to neighbouring hospitals to reduce the number of attendances. From February 2016 to December 2016, the ED was either on full or peripheral ambulance divert 54 times.

Learning from complaints and concerns

- From October 2015 to September 2016 the ED had received 73 complaints. The top three areas complained about were, delays within the department, attitude of staff and diagnostic concerns. Not all complaints were responded to within the trust's timeframe. We saw that some complaints were still open awaiting an outcome up to 16 weeks after they were received. We observed associated learning and actions being put into place following complaints.
- Reception staff told us that if a patient wished to make a complaint they would refer them to the nurse in charge to allow an informal resolution where possible. Nursing staff told us that they would record a complaint on the electronic incident system if this was resolved informally.

- Leaflets containing information about making complaints were available and information was available about how to contact the Patient Advisory Liaison Service.
- Patients, relatives and visitors told us that if they had a complaint they would speak to nursing staff.

Are urgent and emergency services well-led?

Inadequate

We rated well-led as inadequate because:

- There was no clear documented strategy or vision for the ED.
- Policies and procedures were not always in place to support staff. Procedures that were in place were not always followed or adhered to.
- Divisional leadership was not always effective within the ED. There was a lack of clear plans to improve care and flow within the ED to allow safe patient care.
- Staff did not feel listened to or valued by the trust. The department felt that others areas and wards did not support them when caring for patients who no longer needed ED care.
- Accurate risks were present on the divisional risk register. However, they did not all have the necessary mitigating actions in place to reduce patient harm.
- There was poor stability within the ED. There had been numerous interim managers at trust level who all had varying views on how the ED should run operationally. This meant constant changes for staff in the department.

However:

- Departmental risks were understood by all senior and divisional staff.
- Meetings occurred to discuss performance, clinical care and risks within the ED. These were well attended and occurred regularly.
- Nursing and medical staff, including senior nurse leaders, all shared a clear goal to improve patient care and were working to provide this in unsatisfactory circumstances.
- Teamwork was an asset of the department, with nursing and medical staff constantly supporting each other in times of high demand and patient acuity.
- Staff showed they had innovative ideas that would drive improvement in the ED, however, felt they could not be successfully implemented whilst the department had problems with flow and capacity.

Leadership of service

- Leadership within the ED was not always effective. The ED was managed overall by the medicine directorate. The directorate was led by a divisional medical director, a divisional director of operations and a divisional director of nursing. The ED was led at a local level by the directorate manager, the matron and a clinical lead. Some of the divisional team were new to position and had only been part of the trust for several months. Senior nursing and medical staff felt there was, at times, a disconnect between them and the division leads/trust leadership.
- The directorate leaders had an understanding of the department's main risks but were not clear on plans to improve flow or develop the department.
- All staff spoke highly of the nursing leadership provided by the matron and sisters within the ED. Staff told us they were extremely supportive, understanding and shared their vision for high quality patient care.
- Staff also spoke highly of consultant support within the ED. Doctors and nurses felt that they were understanding of demands and tried their best to ensure patient care and safety at all times.
- We were told that senior leadership staff were rarely seen in the department and that most staff had never met the chief executive or any of the executive team. Staff working within the ED felt that directorate leads and senior trust operations managers could be more present, especially in times of high demand to show support.
- Senior medical and nursing staff told us that having numerous interim executives in the trust made it difficult to provide the department with stability and consistency.

Vision and strategy for this service

- There was no documented strategy or vision for the ED. Medical and senior nursing staff had clear views about how they felt the ED could develop going forward and the potential strategy of the service. However, they felt

this was unachievable in the current climate due to consistently having to manage with a crowded department. Staff felt this held them back from improving services and implementing new initiatives in the ED.
- Staff showed an awareness of trustwide values, but did not have knowledge of the trust's strategy. Staff felt that this may be due to continuing changes at executive level, which meant future plans were not always clear.

Governance, risk management and quality measurement

- Risks relating to the ED were contained within the medicine divisional risk register. The top risks for the ED related to crowding, delays in ambulance offloading, ED performance and recruitment. Senior nursing and medical staff, along with divisional managers were aware of the key risks to the department. We were told that the main risks relating to capacity and demand were continuously escalated to a divisional and trust wide level, but with minimal consequence. Risks relating to capacity and poor performance had been present on the risk register prior to our previous inspection in 2015, there was minimal evidence of actions being taken at a trustwide and divisional level to significantly improve these areas and mitigate risks to patient safety.
- There was a disconnect in relation to identifying and investigation of risks within the ED. As staff were discouraged from reporting incidents by the risk management team, there could not be a full oversight of risks if this occurred.
- Concern relating to poor flow, national targets not being met and crowding within the ED were present during our previous inspection in 2015. These risks were not being managed effectively or appropriately from a trustwide perspective. The senior nursing and medical staff working in ED did not feel the trust fully acknowledged the level of risk and patient safety concerns within the ED. They felt they had a clear understanding of the quality of care delivered to patients and how the environmental and overcrowding risks were impacting on this. However, were not assured that this understanding was always apparent at a more senior level.
- Due to the overcrowding in the ED, corridor care was no longer the exception but was normalised at a trustwide level. Risks of patient care and experience in the ED were not continually reassessed to reduce the need to care for patients in corridors. Senior nursing and medical staff working in ED felt that priority was given to other areas of the trust, such as inpatient wards, rather than addressing capacity issues within the ED.
- Policies and procedures were not always in place to support staff within their role. For example, many of the minor injury treatments did not have documented pathways to ensure staff were following best practice. Some areas did not have the necessary standard operating procedures (SOP) in place to ensure correct processes were followed, this included paediatric care within the ED, process for ambulance offloading and cohorting in the department and minor injury treatment pathways. Some processes had a SOP or policy in place, but were not always correctly followed, this included care of patients within the CDU and care of patients within the corridor. We escalated these concerns to the trust during our inspection. We were provided with updated policies for paediatric care in the ED, CDU and also corridor care.
- Meetings were in place to discuss key concerns, risks and areas for improvement within the ED. However, some of these had only been recently established. The local ED delivery board began meeting in September 2016, therefore we were only able to review one set of minutes relating to this board. This board consisted of representatives from the ED, local commissioning groups, the ambulance service, Healthwatch and NHS emergency care improvement programme. Performance, planning and progress were discussed during the September meeting with a focus on improving care and performance within the ED.
- Weekly governance meetings were carried out with attendances from medicine divisional leads and governance leads. Serious incidents, duty of candour notifications and complaints were discussed at these meetings. Whilst learning points were discussed there were minimal medium and long term plans to discuss moving forward.
- Quality assurance meetings were conducted with matrons across the three ED sites in the trust, along with divisional leads. New clinical pathways, improvement initiatives and clinical audits were discussed during these meetings.
- General staff meetings did not occur regularly due to capacity and demand. However, the matron told us they had plans to improve meeting regularity and

attendance to ensure learning and information could be shared. Most staff told us communication about new processes or policies was via email or notices on noticeboards.

Culture within the service

- Medical staff within the ED felt extremely frustrated with the lack of patient flow throughout the hospital and the impact this had on the ED. They told us they felt undervalued and not respected by the trust.
- All medical staff we spoke with told us that consultant support in the department was exceptional and this was one of their main reasons for staying within the trust.
- We observed throughout our inspection that medical staff were delayed taking breaks or did not take breaks at all. Staff told us they did this to ensure patient safety within the department and to help out their colleagues.
- Nursing staff told us that the department had a strong team work ethic and that all staff, medical and nursing, supported each other. Nursing staff told us that whilst they felt valued by their departmental leaders, they did not feel that the trust valued them as a member of staff. Some staff described low morale due to the increasing workload and no clear plans how the trust was going to address problems in the department.
- Within the ED nursing leaders tried to manage staff safety and wellbeing. However, we were told above this level it felt that staff health wellbeing was not considered by the wider trust. ED nursing leaders reported working over their contracted hours because they felt they could not leave patients in an unsafe environment, such as patients receiving care in the corridor.
- All staff, including medical and nursing leaders, felt a significant disconnect between the ED and the remainder of the trust. Staff told us they were not listened to and often felt their opinions were disregarded by the rest of the trust. Staff were disheartened with the environment that they were caring for patients in, they were aware that they could not solve the problem alone but felt no other part of the trust were willing to help. Where on our previous inspection in 2015 we found that staff had hope the situation was going to improve, on this inspection we found staff almost hopeless.

Public engagement

- The trust displayed up to date information about wait times at their EDs on their public website. This helped to ensure the public could make an informed decision about the best place for their care.
- Patient feedback and NHS Friends and Family Test information was discussed at meetings to ensure improvements could be made to the service.

Staff engagement

- Staff meetings were in place to allow staff to voice any concerns or to discuss any areas of improvement. However, these were not always consistent due to demand. Plans were in place to ensure regularity and improve engagement.
- Most of the staff we spoke with told us that they felt confident in raising concerns with senior managers. However, some staff told us that they had raised concerns about crowding and corridor care and that it was their perception that this was unsafe but they felt unable to voice their concerns. When asked why they felt unable to raise these problems they stated that they didn't think they would be listened to.
- Listening in action (LiA) events had begun throughout the trust. Staff we spoke with felt this allowed them the opportunity to engage with the trust and voice areas of concern. LiA had resulted in some changes in the ED that staff felt were beneficial.

Innovation, improvement and sustainability

- We did not see any evidence in relation to innovation within the department; staff told us that due to demand and continuous pressures within the department there was little time for sharing of ideas to improve the service.
- We spoke with several members of staff who had forward thinking ideas and potential projects to improve patient care. However, they felt that until demand on the department decreased it would be difficult to implement and sustain these.

Medical care (including older people's care)

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

Information about the service

Worcestershire Royal Hospital is part of Worcestershire Acute Hospitals NHS Trust. The main hospital was built under the private finance initiative (PFI) and opened in 2002. The Worcestershire oncology centre opened in January 2015, providing radiotherapy services for patients with cancer, the first time these services have been available in the county.

The medical care service at Worcestershire Royal Hospital provides care and treatment for cardiology, clinical haematology, clinical oncology, gastroenterology, general medicine, geriatric medicine, infectious diseases, medical oncology, respiratory medicine and stroke medicine. There are 211 medical inpatient beds and no day-case beds located across 14 wards; acute stroke unit, Avon 2, Avon 3, Avon 4, Avon discharge, cardiac catheter laboratory, Laurel 1 cardiology – CCU, Laurel 2, Laurel- haematology unit, medical assessment unit (MAU), medical high care and short stay, radiotherapy (oncology) centre, Rowan suite and Silver unit.

In July 2015, the Care Quality Commission (CQC) inspected medical care services at Worcestershire Royal Hospital and found they required improvement for safe, effective and responsive, were inadequate for leadership, and good in caring. The service was required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008 regulations and had produced a comprehensive patient centred improvement plan (PCIP), which reflected these requirements as well as additional aims and objectives for the service.

During this inspection, we visited all medical ward areas, the MAU, and the discharge lounge.

We spoke with 30 patients, 73 staff and six relatives visiting patients. We looked at the care plans and associated records of 23 patients. We held focus groups with nursing, medical staff and ancillary staff, as well as spoke to senior doctors and nurses.

Medical care (including older people's care)

Summary of findings

We rated this service as inadequate for safety and well-led and requiring improvement for effective and responsive. We rated caring as good. Overall, we rated the service as inadequate because:

- Patients who required medical care but were cared for on non-medical wards did not always receive reviews from the appropriate medical team. Patients deteriorating in non-medical wards were not always escalated to the medical team in a timely manner.
- The National Early Warning Score (NEWS) is a guide used by medical services to determine the degree of illness of a patient. During our inspection, we found there was no clear oversight of deteriorating patients in escalation areas. For example, we saw that a patient with a NEWS of eight was not closely monitored. This was not in line with the trust policy, which states that NEWS scores above five should be monitored hourly.
- Only 51% of NEWS was escalated appropriately and this was below the trust target of 95%.
- Escalation areas used to accommodate patients did not have appropriate equipment and facilities (for example, resuscitation trolley) to look after deteriorating patients.
- Equipment was not always available to meet patient needs. For example, patients who required assistance with eating were not always served their food on red trays that indicate their need for supported eating, as they were not always available.
- Robust and appropriate systems were not in place for carrying out and monitoring venous thromboembolism (VTE) assessments, which contravened National Institute for Health and Care Excellence (NICE) guidance.
- The governance system in relation to the management of risk did not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.
- Patient weights were not recorded on more than 50% of drug charts.
- There were not systems in place to manage the safe storage of medicines. Medication such as intravenous fluids were stored in resuscitation trolleys which were not tamper evident and these trolleys were left on corridors that could be accessed by unauthorised people.
- The systems, processes and the operation of governance arrangements in place were not effective in terms of identifying and mitigating risks to patients.
- We found records left unsecured on a number of wards we visited and there was a risk that personal information was available to members of the public.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.

However, we also found that:

- The service had a positive culture of incident reporting and there were established processes for investigating incidents.
- There was effective multidisciplinary team working.
- Staff were friendly towards patients and treated them and visitors with understanding and patience.
- Patients were well supported by staff, treated with dignity, respect, and received compassionate care.
- Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were person-centred and unhurried.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- The management of medical patients on non-medical wards such as surgical wards was not always effective. Patients moved to non-medical wards were not always reviewed in a timely manner by a medical staff and the risk of patients deteriorating was not always appropriately managed. For example, we observed a deteriorating patient placed on a surgical ward had not been reviewed by a medical doctor.
- National Early Warning Score (NEWS) audit from September 2016 to December 2016 showed that only 51% of NEWS above five were escalated, which was below the trust target of 95%.
- There was no clear oversight of deteriorating patients in escalation areas. For example, we saw that a patient with a NEWS of eight was not closely monitored. This was not in line with the trust policy, which states that NEWS above five should be monitored hourly.
- Venous thromboembolism (VTE) assessments were not carried out on all patients in line with trust and national guidance. For example, no VTE assessment was carried out on 13 out of 23 patient records we looked at.
- Appropriate systems were not in place to ensure all medicines were stored safely. For example, medication that required cool storage was stored in fridges where temperatures were either below or above the manufacturers' recommended temperature. This was also identified during our previous inspection.
- Intravenous fluids for emergency use were stored unsecured in resuscitation trolleys on corridors in the ward areas. The trolleys were accessible to staff, patients and relatives meaning that the medication could be tampered with and could cause harm to patients.
- Patient's medical notes were not stored securely as they were left in unlocked trolleys that could be easily accessed by unauthorised individuals.
- Patient weights were not recorded on 14 out of 23 drug charts we looked at. Recording a patient's weight is important as it is often used to calculate the appropriate medication dosage required by the individual.
- Fluid balance charts were incomplete in seven of the 13 records we reviewed.
- Not all staff were up-to-date with medicines management training. A completion rate of 36% against a trust target of 90% meant that not all staff had up-to-date knowledge relating to potential risks associated with medicines.
- Staff did not always follow the trust infection prevention and control policy. For example, staff did not always clean their hands after patient contact and suspected notifiable diseases were not always notified as per national guidance.
- A lack of availability of red trays (indicating a patient required support with eating) meant that patients sometimes received food on grey trays. This meant there was a potential risk of patients not being supported at meal times due to lack of equipment.
- Only 30% of nursing staff had completed safeguarding children level 2 training which was below the trusts' target of 90%.

However:

- There was a positive culture of incident reporting and there were established processes for investigating incidents.
- All the wards used the NHS safety thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, catheter and urinary tract infections. Service leads reviewed and identified areas of poor compliance or areas in need of improvement from the audit results.
- A range of forums were used for staff to receive feedback and learn from outcomes of investigations from incidents.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them. For example, staff were familiar with and were encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff from Laurel, Avon 2 and 3 and Evergreen wards that were all aware of how to report incidents.
- The trust established a mortality review process with its "buddy" trust in November 2016 to ensure they had the correct guidance and processes in place to manage the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results. The aim was to record mortality reviews

electronically and to ensure consistent evaluation of data and trends. However, we saw the service had not embedded this process and there were inconsistent mortality and morbidity review meetings.

- In accordance with the Serious Incident Framework 2015, medical care services reported 38 serious incidents (SI's) which met the reporting criteria, set by NHS England, from July 2015 to August 2016. Slips/trips and falls (39%) and pressure ulcers (37%) accounted for 76% of all incidents reported. Incidents were discussed at staff meetings so shared learning could take place and changes were made to practice to prevent reoccurrence.
- Staff received feedback from incidents they had reported via email and the findings of investigations were also shared by senior staff. Staff were able to describe an example of a change of practice following an incident. For example, a patient fell and nurses received additional training following the incident.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2015 to August 2016 Worcestershire Acute Hospitals NHS Trust reported no never events for medical care at Worcestershire Royal Hospital.
- From November 2014, NHS providers were required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff understood their responsibilities and provided examples of when the duty of candour process would be applied. We saw guidance within the service which staff could refer to.

Safety thermometer

- Each ward used the NHS Safety Thermometer, which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care.
- Data collection took place one day each month. The safety dashboard displayed risks, such as falls, pressure ulcers, nutritional wellbeing, medicine incidents and deteriorating patients. The number of patients with pressure ulcers, falls, catheters and urinary tract infections were displayed on a board in ward areas and discussed during ward team meetings. The divisional quality governance team identified gaps and recorded corrective actions which had to be completed within 30 days.
- Across the medical service, the patient safety thermometer showed that the trust had reported 19 pressure ulcers, 15 falls and 22 catheter urinary tract infections from August 2015 to August 2016. The prevalence rate (number per 100 patients surveyed) for pressure ulcers reached its highest point in December 2015. This was followed by a decrease from January to June 2016. There had been an increase in the frequency rate in July 2016 (1.2 per 100 patients surveyed) but this was seen to be decreasing as of August 2016.
- The prevalence rate for falls reported was at its highest point in September 2015. From October 2015 to February 2016, rates decreased although they increased again from March to May 2016. From June to August 2016 there were no falls reported and prevalence rates decreased to zero as a result of additional training implemented.
- The divisional quality governance team oversaw the completion of the safety thermometer and reviewed any actions regarding the non-completion of safety thermometer records.
- Staff teams shared the results of safety thermometer audits. Service leads reviewed areas of poor compliance and improvement.

Cleanliness, infection control and hygiene

- Adequate hand washing facilities and hand gel were available for use at the entrance to the ward areas, within the wards, at the entrance to bays and side rooms. There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. However, we observed staff did not generally wash their hands on the acute stroke unit in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene."
- Monthly infection control audits were undertaken and we saw evidence of patient environmental audits with the scores achieved ranging from 84% to 100%

compliance across the service. However, from the information provided by the trust no actions were identified on the audit tool to improve infection control standards despite some of the wards being below 100%.

- Patient led assessments of the care environment (PLACE) in 2016 showed a standard of 99% in Worcestershire Royal Hospital for cleanliness which was slightly above the England average of 98%.
- Staff were observed wearing personal protective equipment, such as gloves and aprons while delivering care. However, during our inspection we observed nursing staff not adhering to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4- EU Regulation No.852/2004). For example, we observed staff handling cereal and toast on the acute stroke unit with their hands without the use of gloves. The guidelines Food Hygiene Regulation 2006 stipulate that foods must always be handled using serving tongs. The trusts' food and fluid hygiene policy 2015 wholly accepts legal duty to comply with the Food and Safety Act 1990 and states that staff should clean their hands and disposable gloves should be worn before serving patients' meals.
- Green 'I am clean' labels were in use to indicate when equipment had been cleaned.
- Housekeeping staff on the medical assessment unit (MAU) had clearly defined roles and responsibilities for cleaning the environment. We observed they used different coloured mops and buckets for clinical and non-clinical areas. A checklist was used to ensure all aspects of required cleaning were met. This was in line with national guidance and best practice.
- Senior staff for the areas inspected confirmed that any patient with a potential infection was treated in a side room if required. There were processes in place for areas to be deep cleaned.
- Cleaning materials were stored appropriately and were kept securely in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances, which are hazardous to health.
- There were processes and procedures in place for tracking and tracing endoscopes and decontamination records were filed in patient notes to ensure traceability.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This was in line with the Health Technical Memorandum 01-06 guidelines for the decontamination of flexible endoscopes. This included separate dirty and clean areas, and the use of designated staff for equipment cleaning. We saw endoscopes were leak tested, manually cleaned, and washed in washers between 45 to 50 minutes following a full wash cycle.
- The endoscopy team completed weekly water sampling for contamination. We saw evidence of sampling and the results did not highlight any concerns. Staff told us that any incident of contamination was managed by resampling and "closing" the unit until confirmed as clear of contaminants. We saw stringent infection control measures were followed in the endoscope washrooms.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of endoscopy lists to allow additional cleaning times and to reduce risk of infection.
- During our inspection, we found that a patient was treated with suspected acute meningitis on Avon 3 ward. Acute meningitis is a life-threatening inflammation of the tissue layers that surround the brain and spinal cord and is often caused by a bacterial or viral infection. It is a notifiable disease and registered medical practitioners have a statutory duty to notify the local health protection team of suspected cases of certain infectious diseases. We checked the patient's medical notes and found that this had not been notified to the local health protection team. We raised this with the consultant on duty at the time of our inspection.
- We found on Evergreen ward that a patient with MRSA was isolated in a side room to minimise the risk of the spread of infection. However, the door was propped open with a clinical waste bin. There was insufficient personal protective equipment on Evergreen ward (for example, no small gloves) available for staff use and the patient had to leave the side room to use the toilet. We raised this with senior staff who told us that the door was propped open because the patient was claustrophobic. However, we checked the patient's notes and there was no evidence of risk assessment being completed. When we went back to Evergreen ward the next day, we found that the door was kept closed and PPE had been replaced.
- All staff adhered to the "arms bare below the elbows" policy in the clinical areas we visited.

- The haematology ward had protective isolation precaution signs in place and staff followed infection control procedures as per trust policy.

Environment and equipment

- Systems, processes and practices essential to keep people safe were identified, put in place and communicated to staff. For example, portable electric equipment like blood pressure machines had been service tested regularly to ensure it was safe for use and had clear dates for the next test date on them. There were systems to maintain and service equipment as required. Records indicated defibrillator equipment was checked and hoists were serviced regularly.
- Staff had access to pressure relieving support surfaces to prevent patients suffering pressure ulcers. For example, staff said they could easily order pressure relieving mattresses for patients as required.
- The endoscopy unit's environmental audit for October 2016 had an overall score of 96%. The unit was well maintained with separate male and female recovery areas.
- Endoscopes were stored in drying cabinets so that residual fluid did not remain in the channels and they were protected from the risk of environmental contamination.
- We saw copies of the control of substances hazardous to health (COSHH) risk assessments within the wards visited which included guidance on the handling and storage of items such as disinfectant. The risk assessments also covered the precautions for safe handling, which included well-ventilated areas and the use of personal protective equipment.
- Most clinical areas had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on all the wards we visited.
- We found an oxygen cylinder unsecured on the medical assessment unit and three oxygen cylinders left unsecured on Avon 4 wards. We raised this with staff who secured the loose cylinders during our visit.
- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- We observed ward bays and corridors were generally kept clear of equipment, therefore avoiding trip hazards so people were kept safe. However, on the acute stroke unit, we saw hoists stored on the corridors which presented a trip hazard for staff, patients and visitors.
- During the unannounced visit, we observed meal times on Avon 3 ward and found on a white board above the patient's bed that the patient required a meal on a red tray, which indicated to staff that they needed support with eating. However, we saw that their food was on a grey tray. We raised this with staff who told us "the patient would usually have a red tray; but we didn't have any on the trolley."We looked at the patient's food chart, which was up-to-date, and food eaten had been recorded correctly. This meant there was a potential risk of patients being inappropriately supported due to unavailability of red trays.
- Appropriate coloured disposal bags were used for clinical areas. General waste and recycling facilities were available to staff, patients and visitors.
- The new oncology centre building had links to the main hospital meaning that patients who deteriorated and required urgent care could easily be transferred to the main hospital building.

Medicines

- Emergency medicines for resuscitation were stored on dedicated trolleys which were accessible and available for immediate use. There was evidence that most were checked regularly. However, some medicines including intravenous fluids stored on the resuscitation trolleys were not protected with a tamper evident label or seal to provide visible evidence that they were safe to use. This contravened the Resus Council November 2016 guidance.
- We reviewed 23 drug charts and found that patient weights were not recorded on 14 out of 23 of them. Recording a patients' weight is important as it is often used to calculate the appropriate individual medication dosage.
- If patients were allergic to any medicines, this was recorded on their prescription chart. For example, of the 23 drug charts we looked at, we found that allergies had been recorded on all charts. All prescription charts were signed and dated appropriately and there were no missed doses in the drug charts we looked at.
- There were good governance processes in place to ensure that learning from medicine incidents was

undertaken and action taken to prevent them reoccurring. Medicine incidents were discussed at the medicine optimisation expert forum which would then inform the clinical governance group. A well-developed system of reporting across the trust was led by the medicine safety officer. A team of medicine management link nurses also helped to ensure that learning from medicine incidents were cascaded back to the ward teams. For example due to an increase in reports of medicine incidents relating to allergies, all penicillin related antibiotics were stored separately from all other medicines. Following a never event with insulin, changes were made to the whole process of supply and delivery of insulin, which was followed up with training. The distribution of safety bulletins, posters and newsletters were available in clinical areas as well as on staff notice boards.

- The trust participated in a Commissioning for Quality and Innovation (CQUIN) baseline audit. The pharmacy department conducted a 'missed medicine administration due to the medicine not being available (code 3)' audit in March 2016. The aim of the audit was to assess the current level of missed medicine administration and to discover methods of preventing these to optimise patient care. The pharmacy audited a sample of 20% of the occupied beds on each ward. The total percentage of code 3 was 0.40%, this was better than the CQUIN baseline audit of 0.96%. The highest number of missed medicine doses occurred on the medical assessment unit (0.83% based on 484 number of doses prescribed). However, we did not see any evidence of the monitoring or management of the shortfall.
- During our last inspection, we found in MAU that the medicines fridge temperature recording chart had shown temperature in excess of 8 degrees Celsius for three consecutive days in July 2015. The recorded actions to resolve this was to "leave the door open" which was not in accordance with trust policy for the safe storage of medicines. During this inspection, we found that fridge temperatures were either below or above the recommended fridge temperature (between 2°C and 8°C) on the acute stroke unit and on Avon 3 ward. For example, we found on the acute stroke unit that the fridge temperature readings ranged from 0.1 degrees to 1.6 degrees, which were below 2°C as recommended by the manufacturers. Insulin and chloramphenicol (a medication used to treat conjunctivitis) were found in the fridge and required to be stored between 2°C and 8°C. We found that a patient on the ward was currently prescribed chloramphenicol for conjunctivitis which meant that this medication may not work in the way it was intended, and so could pose a potential risk to the health and wellbeing of the person receiving the medicine. We raised this with senior staff who told us that the fridge had been reported recently as undercooling and the pharmacist was aware of the low fridge temperatures (for 13 days) in November. Senior staff confirmed they had made arrangements with the pharmacist to discard medication found in the undercooling fridge. Senior staff also confirmed that staff would continue to monitor the fridge temperatures while waiting for a replacement fridge. However, there was no identified timescale of when the fridge would be replaced.
- We saw on Evergreen ward that the temperature of the medicines refrigerator was not recorded daily. Over 24 days only 12 days temperature records were documented which were within the safe range of 2 to 8°C. It was therefore not possible to determine if medicines were always stored at the correct temperature. We raised this with staff who told us this would be raised with all staff and closely monitored.
- The temperatures in the treatment rooms were within the recommended storage temperature for medicines stored in an ambient environment of 25°C.
- Controlled drugs (CDs) that require extra checks and special storage arrangements because of their potential for misuse were reconciled correctly in the CD book, in line with trust policy.
- We found patient's own controlled drugs stored in the controlled drugs cupboards across medical wards. These were clearly documented in a CD book and where patients had been discharged; they were either returned to the patient or sent to pharmacy.
- A dedicated pharmacy team was based on the MAU seven days a week. They attended the daily ward round in order to deal with any immediate medicine issues. A pharmacist ensured patients received the correct medicines once they were admitted to hospital and ensured they stopped other medication, as necessary. We observed the pharmacist discussing a patient's medicine history with them on admission to the ward. In addition, the pharmacist answered any other questions the patient's had about their prescribed medicines.

- We saw on Silver unit, MAU, and Evergreen wards that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were receiving their medicines when they needed them.
- Nursing staff were observed administering patients' medicines in line with the Nursing and Midwifery Council Standards for medicines management 2007. This included checking the drug, its expiry date, dose and time due. All nursing staff checked the patient's identity prior to administering medication.
- In the theatre assessment unit (which had five medical outliers at the time of inspection) medicines were not stored securely in patient bedside lockers. We saw medication was left on top of patient lockers because no keys were available. This meant that such medication could be accessed by unauthorised persons.
- During our visit to the theatre assessment unit, we enquired about facilities for medicines management. Staff nurse confirmed there was no pharmacy service which meant that routine stock medicines were not available. There was no stock list and processes in place to order medicines. The nurse in charge had no order book and had to call pharmacy to request a book. This was brought to the attention of the pharmacist who quickly responded. They confirmed they had not been informed that the unit was being used as an escalation area. This meant that there were no processes and systems in place regarding medicines management to ensure that the care and welfare of the patients was appropriately addressed.
- The discharge lounge (medical day case) was used as an escalation area for patients medically fit for discharge but had no pharmacy involvement. Waiting times for medicines from pharmacy could be up to four hours which potentially had an impact on patients who required time critical medicines. Nurses would leave the discharge lounge to go to pharmacy to wait or request the urgent medicines direct from the ward. The delays were partly due to the fact that doctors had not written up the discharge medicines in time for pharmacy to dispense. A three month trial of a pharmacy technician working in the discharge lounge was ''really helpful'' but it was not continued due to pharmacy department resource issues. There were no immediate alternative plans in place to address these issues.

Records

- We found that patients individual care records were not always written and managed in a way that kept people safe. Patient individual records were kept at the end of their beds which included for example; care plans, intentional rounding charts, nutritional charts and falls risk assessments. Patients had paper care records drug charts and records seen were legible.
- We looked at 23 records across the service and found inconsistencies in the completion of charts, assessments and care plans in some wards visited. All were brought to the attention of the senior staff in charge. Examples included:
  - lack of VTE assessments (13 records)
  - No weights recorded (14 records)
  - Incomplete fluid balance charts (seven records)
- We looked at six sets of patient's records on the acute stroke unit and found most nursing records, including observation charts, NEWS and drug charts were fully completed and up-to-date.
- Staff used fluid balance charts to monitor patients' fluid intake. However, on seven out of 13 fluid balance charts the fluid input and outputs were not totalled and were sometimes entered incorrectly. This meant that an accurate hydration status of patients could not be measured.
- All individuals assessed as having a grade 1 to 2 pressure ulcer had a documented repositioning chart called intentional rounding chart and these were up-to-date at the time of our inspection. Intentional rounding is a structured process where nurses on wards in acute hospitals carry out regular checks with individual patients at set intervals. During these checks, they carry out scheduled or required tasks.
- Detailed information had been clearly recorded on patient records and showed that all patients had been seen on a ward round within 12 hours of admission, diagnosis and management plans were identified, and nursing assessments and care plans had been completed.
- All wards had lockable patient medical note trolleys. However, these trolleys were left unlocked on Evergreen ward, Avon 3, acute stroke unit and Laurel ward. In the endoscopy unit, we observed that the trolleys which contained patient notes were left opened and unattended in the corridors or recovery areas. This meant they were accessible to patients, visitors and non-clinical staff which increased the potential for patient confidentiality to be breached.

- All computer terminals were secure and locked to prevent non-authorised persons accessing patient information.
- The wards used a patient passport document called "About me" to support care planning for patients with dementia. Screening for dementia assessments were being carried out in the wards.

Safeguarding

- Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. Staff completed safeguarding training through electronic learning and had a good understanding of their responsibilities in relation to the safeguarding of adults in vulnerable circumstances.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to their job role. Medical staff had a training completion rate of 94% for safeguarding adults, thereby exceeding the trust target of 90%.
- Nursing staff had a safeguarding training completion rate of 99% for safeguarding adults. Staff required level two safeguarding children's training as per national guidance. However, records provided by the trust showed only 30% of staff had completed safeguarding children level two training, which was below the trust target of 90%. Senior staff confirmed they did not treat children but were aware of the shortfall and we saw arrangements in place for staff to attend safeguarding e-learning training. We saw training dates assigned on staff notice boards.
- Staff received feedback from safeguarding referrals that they made and received learning from other safeguarding referrals at team meetings and in safety huddles.
- Safeguarding information, including contact numbers of the trust leads were kept on the wards in folders and on staff notice boards, and staff were aware of how to access these. Safeguarding concerns were also discussed at handovers and staff were aware of any ongoing concerns. For example, we reviewed notes of a patient and found that safeguarding concerns regarding potential financial abuse by a close relative had been raised and clearly documented.
- We saw the trust's pathway on arrangements in place to safeguard women or children with, or at risk of, female genital mutilation (FGM). FGM is removal of part, or all of the female genitalia or procedures that intentionally alter or cause injury to the female genital organs and has no health or medical benefit (WHO 2014). Staff said they felt training had much improved since the last inspection which included female genital mutilation training.

Mandatory training

- The trust had set a target of 90% for completion of mandatory training. However, the records showed that the medical staff had not reached its target (overall 73%) with the exception of manual handling. For example; information governance had a completion rate of 60% whilst fire awareness, health and safety, infection control and resuscitation had a training completion rate of between 83% and 85%. Equality and diversity training had the lowest completion rate at 20%, followed by conflict resolution (29%) and medicine management (36%).
- Nursing staff had a training completion rate of 90% to 93% for fire awareness, infection control, resuscitation, and information governance, thereby meeting and exceeding the trust target of 90% in those modules. Medicine management had the lowest training completion rate of 36% followed by conflict resolution (39%) and equality and diversity (39%) training. Health and safety and manual handling had a training completion rate of between 85% and 89% respectively. A training completion rate of 36% for medicine management meant that staff were not up-to-date on safe administration of medication to patients which could pose a potential risk to patients.
- The risk register did not record training. However, the patient centred information plan (PCIP) tracked all training. In response to the training deficit, the service had developed online training and a review of roles to ensure that training was specific to the needs of the role.
- Staff knew how to access the management of violence and aggression policy and confirmed they had received training in conflict resolution and personal safety.
- The mandatory and statutory training programme covered basic life support for adults and paediatric, conflict resolution, equality and diversity, fire, health and safety, infection control, information governance, manual handling, safeguarding children and safeguarding adults.
- Staff individual training timetables were on display on the MAU so staff could clearly see what training they

were not compliant with. The ward manager confirmed they supported staff that had failed to complete their training, or were having difficulties by sending them reminders and offering study days to complete training.
- Mandatory training was discussed during induction for all new starters. Staff said they had undertaken mandatory training relevant to their role.
- Ward managers had access to an electronic system for recording and monitoring staff training records and said they were able to plan ahead in terms of staff requiring training.

Assessing and responding to patient risk

- Systems, processes and practices that are essential to keep people safe were not always identified, put in place and communicated to staff. For example, the service used a venous thromboembolism (VTE) and risk of bleeding assessment tool, which should be completed on admission and re-assessed within 24 hours of admission. We saw that the service did not always follow the National Institute for Health and Care Excellence (NICE) (QS3 Statement 4) reducing VTE risk in hospital patients' guidelines on all wards. For example, of the 23 records seen it was difficult to establish if any patients had been reassessed within 24 hours. This meant we could not be assured that patients had received the relevant assessment to manage their care.
- Medical patients on non-medical wards were not always effectively managed or promptly reviewed by medical staff. For example, during our inspection, we found a medical patient who had deteriorated on a surgical ward and had not been reviewed by a doctor. The patient deteriorated further while waiting for a medical review.
- Four senior medical staff said patients were moved to non-medical wards without being assessed whether they were medically fit to be moved by their doctors. A risk of deterioration was not always managed in a timely manner. This was not in line with the Worcestershire Acute Hospitals NHS Trust patient transfer policy which states that medical staff must determine whether a patient is medically fit for transfer, the benefits of the transfer must outweigh the risks and medical staff must agree and clearly document a plan for the transfer of the patient.
- Nationally recognised risk assessment tools such as malnutrition universal screening tool (MUST) and Waterlow score were used. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm.
- The National Early Warning Score (NEWS) was used for identifying and escalating deteriorating patients. This system alerted nursing staff to escalate patients for review if routine vital signs were out of safe parameters. The NEWS audit from September to December 2016 identified staff not escalating patients with an elevated NEWS appropriately. Only 51% of patients with a NEWS above 5 were escalated appropriately which was below the trust target of 95%.
- Medical patients were nursed on surgical wards and the theatre assessment unit (TAU) which was used as an escalation area. During our inspection, we found that the TAU did not have the appropriate equipment, for example, a resuscitation trolley to look after patients whose clinical condition was deteriorating. Staff were moved from different ward areas to work in the TAU and agency staff were used frequently. There was no clear oversight of the deterioration of patients on the TAU. For example, we saw one incident where there was no evidence of observation of vital signs for four hours for a patient with a NEWS of eight. The trust escalation policy states that if patients NEWS is above five, they should be escalated for a medical review and should have hourly observations. This incident was discussed with medical staff who said that additional reviews and observation of vital signs should have been carried out to improve the quality of care to the patient.
- We observed staff giving a blood transfusion to a patient on Avon 3 ward, two staff nurses checked the patient's identity band, checked that the patient had been cross matched (a test for determining the compatibility between the blood of a donor and a recipient before transfusion), gained consent from the patient and clearly communicated with the patient.
- Senior staff attended a multidisciplinary safety meeting on the ward each morning. This assessed and reviewed patient risk. Each patient was RAG (red, amber, green) rated to determine what intervention was required.
- Patient risk had been discussed with the local ambulance service regarding patients presenting with or developing signs of upper gastro intestinal (GI) bleeds. Patients diagnosed at the Alexandra hospital, would be

transferred by ambulance to the Worcestershire Royal Hospital. We saw the action plan (September 2016) which included the drafting of a standard operating procedure which was to be integrated with the local ambulance service pathway document for upper GI bleed. We saw this had a target completion date of December 2016.

- All patients admitted to the service received a falls risk assessment using a national falls risk assessment tool. Nursing staff informed us that patients identified as being at risk of falls were placed in view or as close to bathrooms as possible. This prevented patients from walking long distances.
- Patients who became unwell during outpatient procedures such as endoscopy or during outpatient clinical appointments were admitted to the service through the medical assessment unit.

Nursing staffing

- During our inspection, we found staffing levels were appropriate. However, the corporate risk register identified there was a risk to the quality and safety of patient care due to difficulties in recruiting to medical and nursing vacancies.
- The hospital used the safer care nursing tool, which was in line with the NICE staffing guidelines and helped the hospital to support safe staffing levels based on patient need. The number of nurses and health care assistants (HCA) required for each shift were calculated using this staffing tool.
- The service had a staffing escalation policy and processes in place whereby the matron or the clinical site supervisor had awareness of any unfilled shifts. We observed the ward matrons attending each clinical area to review the staffing levels, ward activity and offering support to the ward teams. Senior staff confirmed nursing staff often moved to support other wards but they received either agency or bank staff in replacement.
- Following a workforce review in January 2016 the trust decided to continue with their current establishment of one nurse to eight patients across all general wards. However, staffing levels could change on a shift by shift basis if any patient was identified as being a high risk of fall or required increased nursing observations.
- Details of daily required and actual staffing levels were displayed on a notice board in the main ward corridor for relatives and visitors to see.
- As of August 2016, Worcestershire Acute Hospitals NHS Trust reported that their staffing numbers for medical care at Worcestershire Royal hospital had 11 less whole time equivalent (WTE) nursing staff in post than what was budgeted for. As of July 2016 in medical services there were 246.89 nursing whole time equivalents (WTE) and 222.78 other clinical WTE.
- As at August 2016, Worcestershire Royal Hospital reported a vacancy rate of 12% nursing staff in medical care. Hepatitis C blood and specialised clinical services had the highest vacancy rates of 64% and 60% respectively. MAU, gastroenterology doctors, stoma care and vascular doctors had a vacancy rate between 20% and 44%. The acute stroke unit, Avon 2, Avon 4, cardiac catheter lab, Laurel 1 and cardiology CCU had vacancy rates of between 10% and 20%.
- As at August 2016, the Worcestershire Royal Hospital reported a turnover rate of 17% in medical care. Hepatitis C blood reported the highest turnover rate of 88%, followed by pain services (79%) and vascular medics (61%). The acute stroke unit, Avon 3, infectious diseases, Laurel 1, cardiology CCU, Laurel haematology unit, Laurel unit 2 and silver unit all reported a turnover rate above 10%.
- From April 2015 to March 2016, the Worcestershire Royal Hospital reported a sickness rate below the trust average for nursing staff of 5%. Radiology centre, Silver unit, laurel- haematology unit, medical assessment unit, rowan suite and cardiac catheter lab reported the highest sickness rates of 6%.
- At the time of our inspection, we noted high use of agency staff and we were told that there were challenges with recruiting nursing staff. From September 2015 to August 2016; the hospital reported a bank and agency usage rate of 19% in medical care. The highest agency and bank usage was reported for the medical assessment unit (78%), Avon ward (26%) and the medical high care and short stay ward (20%).
- The ward areas had systems in place to manage the induction of agency staff. This included a tour of the ward, introduction to staff and details of the equipment used. We saw completed templates used for this process. Agency staff confirmed that this always happened, even if they had worked on the wards previously.
- Students said they were aware of their supernumerary status and not counted in the number of staff required to staff the ward safely. However, on reviewing the rotas,

we found that students were often included in the numbers to cover staff absences. This was not in line with the trust policy. An example was given when a HCA was sent to another ward because a student was found to be on duty. This meant that supernumerary status of students was not always taken into consideration.

- Nursing handovers took place at the end of each patient's bed or in their side rooms. During an observed handover on the acute stroke unit, we found that nurse handovers were held at the end of the bed and included information about the patients' health condition, cognition and social circumstances. For example, patient's date of birth, diagnosis and treatment plan was discussed. This could be heard by other patients in the bay therefore a patient's privacy and confidentiality was not protected due to the close proximity of other patients.

Medical staffing

- During our inspection, we found staffing levels were appropriate. However, the corporate risk register identified there was a risk to the quality and safety of patient care due to difficulties in recruiting to medical and nursing vacancies.
- As at September 2016, the hospital reported a vacancy rate of 25% in medical care, which was lower than the trust average of 32%. The postgraduate medical centre and specialised clinical services both had a vacancy rate of 100% while stroke medicine and haematology had a vacancy rate of 88% and 72% respectively. High vacancy rate was also reported for rheumatology (46%), respiratory medicine (43%) and MAU (33%). The vacancy rates for consultants were 19% and the rate for other medical staff was 31%.
- As at September 2016, the hospital reported a turnover rate of 12% in medical care. Cardiology reported the highest turnover rate of 127% while high rates were reported for rheumatology (50%), microbiology (42%) and clinical haematology (33%). Seventeen of the 26 units reported a turnover rate of 0%. The hospital reported a turnover rate of 12% lower than the trust average for medical staff of 28%. Other medical staff had the highest turnover rate of 31% while consultants reported a turnover rate of 4%.
- For the period from April 2015 to March 2016, the hospital reported a sickness rate of 1% in medical care which was lower than the trust average sickness rate for medical staff of 3%. Rheumatology and neurophysiology reported the highest sickness rate of 6% while dermatology reported a sickness rate of 5%.
- The risk register had identified the lack of a consultant physician gastroenterologist as a concern. The trust had an ongoing recruitment programme. Where practicable, locum doctors provided additional cover to support the care and welfare of patients at the hospital.
- Staff on the high dependency short stay unit told us that they had one substantive consultant and two locum senior health officers (junior doctors) to look after 15 patients. In order to cover consultant annual leave or sickness, the ward used locum consultants. Senior staff within the high dependency short stay unit said that on occasions it was difficult to contact the consultant within the hospital due to them working in other departments. This meant that there was a potential risk of patients not being seen in a timely manner by a senior doctor.
- There was 24 hour on-call registrar cover and FY2 (foundation doctor)/registered medical officer cover across the hospital. In addition, there was an FY2 on a late shift in the medical assessment unit and a late FY2 for the wards from 3pm to 1am and Monday to Thursday additional FY2 cover from 4pm to 4am.
- Night cover on the wards was from a registrar, a FY1 (house doctor) and an advanced nurse practitioner (ANP). The role of the ANP was to be a link between medical and nursing teams. There were no ANP facilities at weekends and the nurse in charge undertook the assessment of patients.
- There was general medicine consultant cover on-call seven days a week. Senior medical staff confirmed they could attend the hospital within the required 30 minutes.
- During the last inspection in 2015, significant concerns were raised both in terms of effective recruitment at consultant level and also for out of hours and weekend medical cover provided. Doctors felt overstretched and said the level of medical cover in the evenings and weekends was not sufficient at times. The corporate risk register also acknowledged that, if the medicine division was unable to sustain appropriate staffing levels it will be unable to provide safe patient care.

Major incident awareness and training

Medical care (including older people's care)

- Arrangements were in place to respond to emergencies and major incidents. For example, there was an emergency plan covering internal and external incidents. There were major incident response plans on the trusts intranet which could easily be accessed by staff.
- The trust's winter plan for 2016/2017 summarised how the trust would provide an integrated approach to deliver services across Worcestershire. Four common factors were identified which may exacerbate winter pressures. These included:
  - Norovirus
  - Adverse weather conditions
  - Seasonal illness such as flu and other respiratory illness
  - Staff shortages due to the above
- The divisional plan 2016/2017 for medical services identified five priorities in the trust winter plan. These included streaming in the emergency department, patient flow, and discharge of patients, escalation and workforce.
- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply.
- Regular testing of generators occurred in case there was a failure of the electricity supply to the hospital.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.

Are medical care services effective?

Requires improvement

We rated effectiveness as requiring improvement because:

- Patients did not always receive effective care and treatment that met their needs. For example, patients did not always receive analgesia (pain relief) in a timely manner.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.
- Nursing staff did not always provide support to patients requiring assistance with eating and drinking at meal times.
- During nurse handover on the acute stroke unit confidential information could be overheard by other patients in the bay.
- Staff did not recognise that high-low beds were a form of restraint as well as providing safety for patients, therefore did not complete the appropriate Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) assessments. Only 41% of staff had completed MCA and DoLS training.
- Staff did not always review and assess the patients' nutrition and hydration needs to ensure they met the patient's individual requirements.
- The service reported variable performance in a number of national audits relating to patient safety and treatment. We requested action plans from the trust which were not provided.

However:

- Inpatient hospital care for cardiology inpatients was better than the England average with scores higher than the England average by 10%.
- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- There was evidence of effective multidisciplinary team working within the service.
- Most patients stated that they received appropriate pain relief. However, two patients stated that they had asked for pain relief medication which was delayed with one saying they were left in pain for four hours with no clear explanation.

Evidence-based care and treatment

- Policies were relevant and accessible by staff via the trust's intranet system. These were based on national and best practice guidelines to care for and treat patients. The service were monitoring compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified. Staff understood appropriate NICE guidelines and stated these were referred to in discussions with staff about patients' care and treatment.
- Assessments for patients covered all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs. Although

patient's care and treatment was planned and delivered in line with evidence-based guidelines we found areas which the service were not monitoring effectively which included VTE assessments and NEWS charts.

- The service had a series of care bundles in place based on national guidelines, such as NICE and Royal College of Physicians. This included guidance for the assessment and treatment of medical conditions such as dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), sepsis (blood infection) and acute kidney injury.
- We looked at the trusts' guidelines for management of sepsis and septic shock in adults and found it had been updated in August 2016 to reflect new sepsis definitions, NICE guidance and the WAHT 'Suspected Sepsis' screening process. Sepsis is caused by the way the body responds to germs, such as bacteria, getting into the body. Adapted guidelines on quality standards for sepsis screening and management was stored in the resuscitation trolley across all medical wards we visited.
- The trust had introduced a sepsis screening box to the wards. A sepsis screening box was used as an early intervention tool to save patients identified with possible sepsis. The box ensured everything required was to hand and easy to administer in the correct order. It made replenishment easy and enabled infection control.
- The service participated in the Commissioning for Quality and Innovation (CQUIN) framework which encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare which means better experience, involvement and outcomes. We saw the service participated in the sepsis CQUIN and the record showed that FY1 and FY2 doctors (foundation doctors) had received an induction into the programme. Areas covered included the recognition of sepsis, the use of the sepsis six tool (the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis) and NEWS charts.
- Once transferred from the medical assessment unit of the hospital to acute wards, patients were reviewed during consultant delivered ward rounds once daily and seven days a week. However, medical outliers were only reviewed during week days and on weekends if their condition deteriorated.
- We saw effective treatment planning recorded in nursing and medical notes for the implementation of care and treatments in line with national guidance.
- The Joint Advisory Group (JAG) on gastrointestinal endoscopy found that the endoscopy services met the accreditation standards framework such as policies, practices and procedures. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards.
- Endoscopic procedures, for example, diagnostic upper and lower gastrointestinal examinations were carried out in line with professional guidance. We reviewed the endoscopy care pathways, which included the World Health Organisation (WHO) 'Five steps to safer surgery' checklist.
- Care pathways were in place for managing patients that needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The care pathways were based on NICE guidance.

Pain relief

- We found there was a consistent approach to assessing and managing pain.
- The trust used the National Early Warning Score (NEWS) chart to assess a patient's pain levels. As of October 2016, the trust was using the Abbey pain control scale to measure the pain in people living with dementia, delirium or express (ideas or feelings) in words. However, staff said they were unaware of the new tool and were currently using the scale within the NEWS chart.
- Staff had access to pain management services provided by a dedicated pain management team. They were easily accessible and when required attended the ward and reviewed patients who were prescribed analgesia (pain relief) but their pain was not under control. The effectiveness of pain relief was evaluated and recorded in the patient's records by using the pain scale within the NEWS charts.
- During our inspection, we spoke to two patients who told us that they requested analgesia and had to wait over four hours for it to be administered. However, seven patients said they had been offered pain relief and felt their pain was being managed appropriately. We observed staff asking patients about their pain.

- Patients' pain scores were not audited, which was part of the monthly NEWS audit conducted by the critical care outreach team. However, we saw that the level of pain patients reported was recorded on early warning scores documentation.
- The patient's medicine administration records (MAR) charts showed that pain evaluations with appropriate medicines prescribed and the effect of analgesia individually evaluated.
- Staff discussed patient's pain at nursing and medical handovers when appropriate.
- The endoscopy unit recorded patient's pain scores appropriately. This was in line with the requirements set out by the Joint Advisory group (JAG) guidelines.

Nutrition and hydration

- There were inconsistent processes in place to support patients that needed assistance with eating and drinking. Patients were offered drinks to promote hydration. However, staff

did not always assist patients with eating in a timely manner.

- Red trays, cups and jugs were in place to highlight patients who needed assistance with eating and drinking. Red trays were used in wards to help staff identify which patients required support when eating. We observed a mealtime on Avon 2 ward and saw that patients who required assistance with eating and drinking were not always supported appropriately. Two trays were left on tables and could not be reached by patients. We also saw a patient who required assistance with eating and drinking was not sat up to assist them eat their meal, and another on a high-low bed who could not reach their food easily. This was brought to the attention of senior staff on duty. However, during the unannounced visit, we saw that patients on Avon 2 were appropriately assisted with eating by staff.
- The trust used the Malnutrition Universal Screening Tool (MUST) as a way of screening patients who may be underweight or at risk of malnutrition. All patients had nutritional assessment completed on admission.
- There was a daily nutritional round for patients who received parenteral nutrition delivered by the dietitian and pharmacist together. There was a weekly nutrition round delivered by the nutrition team, which included the consultant, dietitian, nutrition nurses and pharmacists.
- Medical staff on Avon 2 told us that a business case had been submitted for a nutrition nurse who would be the main point of contact for all patients receiving parenteral nutrition. Parenteral nutrition is a method of getting nutrition into the body through the veins.
- The hospital provided meals to meet the needs of individuals. For example, patients could have halal food and when patients were fasting, they would have sandwiches available as required.
- The Ambulatory care service received patients referred through their GPs from 8am to 8pm, Monday to Friday with consultant cover from 8am to 5pm and nurse cover from 8am till 8pm. We observed drinks being offered to patients while they were waiting to be seen.
- We saw that patients had jugs of water on their bedside tables within reach to promote hydration.
- Of the 30 patients spoken with, 28 were happy with the standard and choice of food available. If patients missed a meal, as they were not on the ward at the time, staff were able to order a snack for them.
- Staff confirmed they referred patients to a dietitian as required. We saw referrals within the records with no issues or concerns highlighted with the timeliness of access. Senior staff also confirmed patients who may be obese had access to a dietitian to support their needs.
- Nursing staff were able to access dietetic support at weekends via a telephone call to the on call team.

Patient outcomes

- The effectiveness of care and treatment was regularly reviewed through local clinical audits and national audits. For example, Worcestershire Royal Hospital took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in eight metrics and worse than the England average in nine metrics. The indicator regarding "Insulin errors" had the largest difference versus the England average (24% worse). There was an action plan to improve performance.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In September 2016, the trust reported a figure of 106, which was higher than expected (100). This was lower than the reported figure of 110 for 2015.
- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether

the number of in-hospital deaths is higher or lower than would be expected. The quality account report for 2015/2016 stated the HSMR value for the rolling 12 months to January 2016 was 105. The comparable peer group figure is 100.

- As a result of the HSMR and SHMI data the trust embarked on four work streams to identify and address avoidable lapses in care that would be expected to impact on avoidable mortality as part of the overall trust improvement programme. These included:
  - Routine review of the care of those dying whilst an in-patient
  - Reduction in avoidable cardiac arrest
  - Ensuring patients with sepsis are identified and treated within an hour of presentation
  - Ensuring all patients presenting with a fractured neck of femur (hip) receive rapid treatment, specifically surgery within 36 hours of arriving at the hospital.
- The hospital took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A to E, where A was best, the trust achieved grade D in the latest audit from January 2016 to March 2016. The team centred key indicator level for thrombolysis declined from level C from October to December 2015 to level D from January to March 2016. Multidisciplinary team (MDT) working improved from level D to level C and discharge processes improved from level C to level B. We requested an action plan from the trust to verify what actions had been taken to improve their SSNAP score, however it was not provided.
- The results in the 2015 Heart Failure Audit were better than the England and Wales average for four of the four standards relating to in-hospital care and four of the seven standards relating to discharge. Inpatient hospital care for cardiology inpatients and input from specialists was better than the England average with scores higher than the England average by 10%. Discharge care standards for referrals to heart failure liaison officers and referral to heart failure liaison officers were both better than the England average by 30% to 40%.
- The hospital partook in the Myocardial Ischaemia National Audit Project (MINAP) audit. MINAP is a national clinical audit of the management of heart attacks. The hospital scored better than the England average for Worcestershire Royal Hospital. We requested an action plan from the trust to verify what action the service had taken to manage and maintain good outcomes. The trust did not provide an action plan.
- From March 2015 to February 2016, patients at the hospital had a lower than expected risk of readmission for non-elective admissions and the same expected risk for elective admissions. The readmission risks for elective admissions were higher than expected for clinical haematology and gastroenterology although lower for medical oncology.

Competent staff

- Not all staff had the appropriate clinical skills and experience for their roles and responsibilities within the clinical area worked, although students and temporary staff were well supported. There were processes in place to identify training needs, compliance, and to implement changes to practice to address any identified issues. However, compliance rates were found to be low.
- From April 2016 to August 2016, 79% of staff within medical care at Worcestershire Acute Hospitals NHS Trust had received an appraisal; this did not meet the trust target of 85%. Appraisal rates for medical staff had declined from 83% from April 2015 to March 2016 to 75% from April to August 2016, while appraisal rates for non-medical staff had improved from 76% to 82%.
- During the last inspection, there were no clear mechanisms in place to ensure appropriate levels of formal supervision of all staff. During our recent inspection, we found there continued to be no clear structured approach for regular operational and clinical supervision. Senior staff confirmed awareness of the shortfall and stated this was a work in progress.
- Following a never event at the Alexandra Hospital, the trust instigated additional training in the administration of insulin on medical wards. The records received showed that from December 2015 to November 2016, only 16 (11%) nurses had completed their training. This meant there could be a risk of staff attending a diabetic patient without the necessary skills to administer insulin.
- There was an induction programme for all new staff. This included mandatory training and competency based ward skills. All staff that we spoke with confirmed they had attended an induction.
- Nursing staff were supernumerary for a short period when commencing a new role. This was to ensure competence and offered new staff the opportunity to learn new skills and methods of working.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able

to manage patients safely. Examples included; heart rhythm recognition, performance of electrocardiograms (ECG - tracing of the heart) and heart failure recognition and management and competencies in administering chemotherapy.

- Newly qualified nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- The trust offered planned study days and drop in sessions for nurses and medical staff from professional development nurses regarding their revalidation. Nursing and medical staff could attend local team meetings as requested by them. The trust's intranet page provided further links to relevant information including the Nursing and Midwifery Council.
- We looked at a student information board and student's comments in the endoscopy unit. A student commented, "the support I received from mentors has been amazing. They have worked hard to ensure my experience here has been varied and a good learning environment for me".
- Student nurses said they felt supported by staff of all disciplines. Medical staff took time to explain things. Some mentors made time to complete workbook reviews. They all felt able to speak to anyone for support.
- During our focus group, we asked students of what was good about the trust and they said "Mentorship is better here than other trusts we have worked in".

Multidisciplinary working

- People with complex needs received prompt screening by a multi-professional team. Multidisciplinary team (MDT) working was established on the medical wards. This included medical staff, nursing staff as well as therapy staff such as a physiotherapists and occupational therapists.
- Clinical teams had weekly MDT meetings to discuss patients. These included the consultant, ward doctors, ward managers, the discharge coordinator, physiotherapists, occupational therapists, speech and language therapists (SLT), dietitians and palliative care if needed.
- We observed an MDT meeting attended by doctors, physiotherapist, occupational therapist, staff nurses and student nurses. The MDT reviewed all patients within 24 hours of admission to the hospital, which identified baseline conditions to formulate treatment plans. This included a review from the ward pharmacist and if appropriate the physiotherapist or occupational therapist.
- Key information about older people with complex needs was communicated to members of the community health team via ward staff and discharge coordinators.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered coordinated care to patients.
- Staff undertook daily ward rounds seven days a week. This involved medical and nursing staff together with physiotherapists and occupational therapists as required.
- Discharge coordinators attended the wards daily to assist with the movement of patients across wards and assist with tasks to promote early discharge. This included arranging transport, liaison with relatives and care placements. Staff knew how to contact discharge coordinators when required and were visible within the wards.
- Nursing staff told us that relationships with medical staff and other professionals were inclusive, positive and promoted multidisciplinary working. Ward sisters reported that the working relationship with the speciality consultants was strong.

Seven-day services

- The pharmacy was available Monday to Thursday 8.30am to 5.30pm, 8.30am to 5pm on Fridays with a limited service on Saturday and bank holidays (10am to 12.30pm). The pharmacy was closed on Sunday. There was a restricted pharmacy service at weekend. A business case had been put in for permanent pharmacy services over the weekend.
- Staff could access pharmacy out of hours when required. There was an out of hour's emergency cupboard, which was accessible by nursing staff for any medications prescribed that were unavailable on the wards.
- The endoscopy unit operated a weekday service with two sessions per day. Additional weekend clinics were included to reduce the waiting lists and any demands on urgent referrals.
- The medical consultants provided weekday cover between 8am and 6pm, with on call facilities overnight and at weekends. All wards reported that at weekends,

patients would continue the treatment plans identified by their consultant unless they became acutely unwell. The consultant on call would then review the patients and advise on any changes to clinical treatment. Medical patients on surgical wards were only reviewed by medical consultants if they became acutely unwell.
- Physiotherapy and occupational therapy services were available seven days a week on the acute stroke unit.
- The ambulatory care unit operated from Monday till Friday from 8am till 8pm and received referrals from GPs directly. The service was not available out of hours and at the weekends.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- Staff reported that they had access to all information required to review patient's conditions and plan safe care and treatment.
- Trust policies and guidance was available on the trust intranet, and staff demonstrated how they accessed the information.
- All clinical areas had access to patient records. Notes, such as risk assessments and observation charts were by the patient's bedside while medical notes were stored in lockable trolleys at either the nurse's station or the entrance to bays. However, we found that these trolleys were left unlocked across medical wards meaning that patient confidential records were accessible to unauthorised individuals. We raised this with senior staff on duty.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information. Policies, protocols and procedures were kept on the trust's intranet which meant staff had access to them when required.
- Patient boards on the wards had details of patient's surnames which identified which bay and bed patients were in with their estimated date of discharge. Patients with particular needs were highlighted using symbols (to protect confidentiality) to indicate the person was at risk of falls, or their dietary needs and whether SLT were involved. Staff were able to access electronic diagnostic results such as blood results and imaging to support them to safely care for patients.
- Staff had access to files in the relevant department offices such as information about Control of Substances Hazardous to Health (COSHH) relevant to their working environment.
- To ensure continuity of care within the community, care summaries in the form of discharge letters were sent to the patient's GP upon discharge.
- Where patients required to be transferred to other ward areas, staff gave comprehensive handover over the phone to nursing staff receiving the patient. For example, diagnosis, care plan and estimated discharge date was discussed during handover.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. However, as at September 2016 MCA and Deprivation of Liberty Safeguards (DoLS) training had been completed by 41% of staff at Worcestershire Acute Hospitals NHS Trust within medical care. We saw evidence of out of date and booked training displayed on boards in staff rooms and senior staff said they encouraged their staff to attend.
- The mandatory e-learning package provided to staff included safeguarding, information about the MCA and DoLS. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing.
- We reviewed notes of three patients who had a DoLS in place and found that the form had been faxed to the local authority and DoLS were reviewed after seven days in line with guidance.
- On Avon 2 ward a patient had been placed on a high-low bed following a fall but no mental capacity assessment was carried out and no DoLS had been completed. Staff said the patient was admitted with delirium (confusion) and were not aware that a potential assessment for MCA or DoLS needed to be completed. A high-low bed is an electric bed which can either be raised or lowered and is used for individuals with risk of falls. We observed that due to the patient being placed on a high-low bed, they were unable to

access their drink or call bell. We raised this with senior staff that using a high-low bed on a mobile patient prevents the patient from getting out of bed and this was a form of restraint. The trust's patient slips, trips and falls policy states that following an assessment and implementation of the 'at risk of falling from bed' care plan, the use of high/low beds should be considered for patients who have been assessed as at high risk of falling from a bed where all other fall prevention measures have been unsuccessful. However, when we reviewed the patient's end of bed notes, we found no evidence of falls risk assessment carried out and there was no evidence to show how risk could be mitigated.

- Both nursing and medical staff understood consent, the decision-making requirements and guidance. The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent (called consent form four) for their operation or procedure and another for procedures under a local anaesthetic.
- Medical and nursing staff understood when to use the forms and whether the consent provided was implied, verbal or written. Implied consent is "consent which is not expressly granted by a person, but rather by their actions and the facts and circumstances of a particular situation". Verbal consent means that patients "read a verbal version of a consent form such as an information sheet and give their verbal consent rather than a written consent."
- Endoscopy staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff confirmed all patients who lacked mental capacity were consented by the consultant using consent form four prior to any endoscopic procedures.
- Medical staff in endoscopy told us that if patients withdrew their consent during an endoscopic procedure, the procedure would be abandoned as per the patient's wish.

Are medical care services caring?

Good

We rated caring as good because:

- Patients told us that the staff were caring, kind and respected their wishes.
- Patients were involved in their care, and were provided with appropriate emotional support.
- The data from the hospital's patients' satisfaction survey Friends and Family Test was cascaded to staff teams.
- Patients and their relatives were positive about their experience of care and the kindness afforded them.
- Patients were involved in their care and chaplaincy services were available to provide people with appropriate emotional support.
- Most patients were positive about their experience.
- We observed staff being friendly towards patients and treating them and visitors with understanding and patience.

Compassionate care

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner.
- Patient's privacy and dignity was mostly respected, including during physical or intimate care. For example, we spoke with patients who told us that staff always pulled the curtains when assisting them with personal care. Patients felt their privacy was respected and they were treated with courtesy.
- The Friend and Family Test (FFT) response rate for medical care at the hospital was 17%, which was worse than the England average of 26% between August 2015 and July 2016. We requested an action plan from the trust to verify what the service had taken to manage the outcomes. To date and time the trust has not provided us with this data.
- The trust participated in the National Cancer Patient Experience Survey 2015, (published in July 2016). Patients were asked to rate their care on a scale of zero (very poor) to 10(very good). The trust's overall rating was 8.7. Between October 2015 and March 2016, 1,278 eligible patients from the trust were sent the survey, and response rate of 70% was achieved, which was better than the national rate of 66%. 92% (482) patients said the hospital had told them who to contact if they were worried about their condition or treatment after they left hospital and 77% (850) patients said that they were involved as much as they wanted to be in decisions about their care and treatment.
- We observed staff used the "Hello, my name is" campaign. The aim of the campaign is to encourage all

staff to introduce themselves to the patient and visitors to improve the hospital experience of all patients. Patients confirmed staff introduced themselves and spoke to them appropriately.
- On Evergreen ward, we observed staff talking kindly and patiently to a patient suffering from dementia who wanted to go home, until they became less distressed.
- We spoke with 30 people visiting relatives. Patients were positive about their experience within the inpatient services. Staff spoke in a kind and considerate manner with patients and their relatives.
- Nursing and administration staff ensured patient confidentiality was maintained and were observed asking patients permission to share information with family members.
- Before entering a patient's room, we observed staff knocking on doors. We saw staff closing curtains to protect patients' privacy.

Understanding and involvement of patients and those close to them

- Patients told us they were involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness or injury might improve or progress. Positive comments we received were; "treatment is always explained to me and I am given options and can pick which one I want", "the medical staff always explain everything to me; I feel I am in the right hands", and "staff always explain and talk me through the treatment".
- Relatives we spoke with were happy with the care received and felt they had been kept involved with their loved ones' treatment.
- Patients said they felt safe on the ward and had been orientated to the ward area on admission.
- Wards had a named nurse system so patients and their relatives generally knew who was looking after them.

Emotional support

- Patients and their relatives told us that clinical staff were approachable and they could talk to staff about their fears and anxieties.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- Patients reported staff always introduced themselves and were very respectful and showed kindness.
- Staff were aware of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.

Are medical care services responsive?

Requires improvement

We rated responsive as requiring improvement because:

- Medical outliers were not always cared for in environments that had necessary equipment (for example, resuscitation trolleys) and facilities such as bathrooms to respond to their needs.
- There was a high volume of patient moves at night from 10pm to 6am, which contravened with the trust's patient transfer policy, which states that internal transfers between wards should occur between 7am and 9pm. There were 3293 moves across all medical wards with average bed moves of 411 (13%) per month.
- Patients were moved to non-medical areas such as surgical wards without consultant knowledge and oversight.
- Staff dealt with complaints within 45 days. This was not in line with the trust's complaints policy which states that complaints be dealt with and closed within 25 days.
- The discharge lounge had to stay opened at least three nights per week due to capacity pressures.
- The discharge lounge had no dedicated pharmacist and on occasions, patients waited up to four hours for to take away (TTA) medication.

However:

- The medical service had developed good working relationship with the Clinical Commissioning Groups (CCGs) in the development of integrated services linked to community and acute services.

Medical care (including older people's care)

- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been the same as the England overall performance.
- There were mechanisms in place, which provided patients with additional support due to their complex needs.
- For patients living with dementia the trust promoted had introduced little twiddle bags to assist with restlessness as promoted by the dementia society.
- Additional waiting lists were organised across the service to ensure patients received timely treatment.

Service planning and delivery to meet the needs of local people

- We observed an integrated approach to care delivery across all the wards involving nursing staff, therapists and medical staff and a commitment to timely, safe and person-centred discharge for the patient.
- Patients were moved frequently around the hospital and the trust was working with local commissioners to improve access and flow and improve bed availability, which included medical care.
- The care of elderly team was working alongside the Clinical Commissioning Groups (CCGs) to actively develop good working relationships. The aim of the interaction was to facilitate the development of integrated services for patients as well as linking community and acute services to promote patient flow through the hospital into community based provisions.
- The hospital had a system which allowed GPs to refer directly to the ambulatory care unit which was linked with medical assessment unit (MAU). The ambulatory service was available from 8am to 8pm. Patients could present to the dedicated nurse or consultant in ambulatory care at these times. After 8pm, GP referred patients would have to present to the emergency department.
- The hospital had Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation. The JAG accreditation scheme is a patient centred scheme based on the principle of independent assessment against recognised standards which included; the provision of a knowledge base of best practices, continuous improvement in processes and patient outcomes and to provide comparisons with self and others. We saw a copy of the business plan which had been approved to support and delivery of a service which would meet the needs of local people.
- Patients said the service met their needs. Relatives confirmed the service was flexible and provided choices. This meant the service had reviewed the continuity of care which best met the needs of the patients.
- The infection prevention and control team (IPCT) provided educational sessions for housekeepers and porters. Consultant microbiologists provided antimicrobial prescribing updates to medical and non-medical prescribers and via mandatory training for clinical trust staff. The IPCT also contributed to doctors induction workshops and provided infection prevention guidance and training for maintaining asepsis, peripheral cannulation, central vascular device management, blood culture sampling and phlebotomy.

Access and flow

- From April 2016 to November 2016, the number of patients on medical wards that were transferred to another ward from 10pm to 6am at night was at 3293 across all medical wards with average bed moves of 411 per month. The trust had a patient transfer policy which states that internal transfers between wards should occur between 7am and 9pm. Out of hours internal transfers should occur if clinically indicated. Information showing the reasons why these moves had taken place during the night was not available. The service was monitoring the number of moves within the departments; however, the trust's target around bed moves was unclear and it was unclear how the trust was planning to improve this.
- From August 2015 to July 2016 43% of patients did not move wards at Worcestershire Royal Hospital during their admission, 45% moved once and only 12% of individuals moved wards twice or more during their admission. Although the trust monitored wards move figures, it was unclear what target they were working towards.
- We visited the discharge lounge as part of the inspection. This lounge was open from 8am to 8.30pm Mondays to Fridays and at weekends from 10am to 6pm. The lounge also supported medical day case patients. The discharge lounge provided seven chairs and had three to five beds to accommodate patients who required beds. Staff on the discharge lounge reported capacity pressures and told us the discharge lounge had to be opened for three to four nights per week for the last five months prior to the inspection.

Medical care (including older people's care)

- The discharge lounge had no dedicated pharmacist and staff reported that on occasions, patients waited up to four hours for to take away (TTA) medication.
- From April 2015 to March 2016, the average length of stay for elective medical patients was 4.3 days, which was worse than England average of 3.9 days. For medical non-elective patients, the average length of stay was 6.8 days, which is similar to England average of 6.6 days. We saw the average length of stay from July 2016 to December 2016 across the MAU was 1.84 days, which was better than the England average of 4 days.
- The risk register for medical care directorate showed they had recognised the risks with regard to patients' length of stay if there were blockages in the pathways. We saw a target date of December 2016 to improve this. Actions included working with the commissioners to access the relevant pathways.
- To improve patient flow within Worcestershire, the trust had agreed with other organisations to support a systematic process for dealing with capacity and demand issues. The aim of the patient flow centre (PFC) is to collect, review and act on all data from across the whole health and social care system related to bed and service capacity and demand. The purpose of the PFC is to provide accessible admission, transfer and discharge data.
- We saw that all clinical areas completed daily board rounds, which included nursing, medical, therapy staff, and discharge coordinators. The board rounds reviewed of all patients, the actions required to enable a safe discharge.
- In order to ensure that services provided reflected the needs of the population served and provided continuity of care, medical services had a designated ambulatory care unit which saw patients on an outpatient basis for further tests or follow up assessments to avoid unnecessary admission or a longer stay in hospital. Referrals were from GP's and the emergency department. Staff told us that there was a clear standard operating procedure which included inclusion and exclusion criteria for the types of patients suitable for the service to ensure they received the best care available.
- The trust had a programme to improve discharge from acute hospitals through three pathways:
  - Pathway 1 – home with support
  - Pathway 2 – community hospital for rehabilitation
  - Pathway 3 – discharge to access
- There were designated discharge coordinators, who would oversee patients' discharge arrangements and discharge plans were discussed at multi-disciplinary team (MDT) rounds.
- There was a discharge team who supported patient discharges that were complex or required rapid discharge. Discharge co-ordinators were allocated to medical wards to support the process for meeting individual needs.
- Staff discussed discharges at the bed management meeting. We observed a bed management meeting which was attended by matrons, the bed management team and a senior manager.
- Patients who were fit to leave the hospital had their discharge plans discussed by medical and nursing staff during ward rounds. They were identified on a discharge board which confirmed all arrangements were in place, such as care packages, transport, and to take away (TTAs) medication had been ordered. Plans were also discussed and put in place for patients to be discharged at the weekend. This meant that patients were not kept in hospital longer than necessary.
- Discharge plans were commenced on admission and patients had estimated dates of discharge documented in their records.
- From August 2015 to July 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services was the same as the England overall performance. The latest figures for July 2016 showed 87% of this group of patients were treated within 18 weeks. For example; the following specialities were just slightly above the England average:
  - gastroenterology 96% against the England average of 95%
  - geriatric medicine 100% against the England average of 99%
  - rheumatology 100% against an England average of 97%.
- Across the trust there were around 1,000 patients waiting for a colonoscopy (a test that allows the examination of the inner lining of the large intestine (rectum and colon). The trust had a waiting list initiative to manage the risk of patients on the waiting list, which included additional clinics at weekends. Staff confirmed they were aware of the initiatives and had participated in weekend working as appropriate. Three patients said they had not waited very long for an appointment, only a few weeks and had no concerns.

- There was a senior nurse on call out of hours. This role rotated through the senior nursing staff across all medical specialities. Their role was to attend the bed management meetings and assist with the management of flow through the hospital, offering clinical advice and support to staff. The senior nurse on call during the inspection reported cover from 5pm to 10pm, but often individuals would remain on site later. Each senior nurse completed a templated report for the night's activity, which included any staff moves, details of any clinical emergencies and reasons for opening of escalation areas.
- The hospital had a bed management strategy and escalation policy to respond to short term bed shortages across the service to support the admittance and discharge of patients. We observed bed monitoring discussed during staff huddle meetings.
- The service had an escalation policy for on-call bed utilisation. The policy outlined the action staff took when activity increased which included the opening of additional clinical areas. The policy identified whose responsibility it was to ensure patient safety. When the policy became active, staff understood and identified their roles and responsibilities.

Meeting people's individual needs

- Services were planned, delivered, coordinated and took account of people with complex needs, for example, those living with dementia. The 'butterfly' scheme was used to discreetly identify patients living with dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support was available. This ensured staff knew to take more time when communicating with patients who had difficulty understanding information and offered additional help, or supported with tasks where needed, such as eating, drinking, going to the toilet and being accompanied off the ward.
- The hospital provided dementia link nurses on most wards to help support effective care for people living with dementia. The hospital used the "About Me" passport documentation. Patients and families completed the passport whilst ensuring relevant information enabled staff to provide person centred care.
- We found that little twiddle bags were given to patients living with dementia and this was promoted by the dementia society. Twiddle bags are knitted muffs and can be helpful to combat restlessness in people living with dementia.
- Patients with learning disability attending for an endoscopy procedure were allowed to have a relative with them both before and after their procedure.
- Medical patients moved to non-medical wards were not always cared for in environments that had necessary equipment (for example, resuscitation trolleys) and facilities such as bathrooms to respond to their needs.
- The oncology centre had acute oncology assessment rooms and two CT scanners to enable separate scanning for radiotherapy planning which meant that newly diagnosed patients could have urgent CT scans and proceed with treatment without delays.
- There were arrangements in place for people who needed translation services. For example, translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format for people living with dementia or learning disabilities. Staff could download leaflets in different languages from the intranet.
- On the endoscopy unit, we saw post procedure information leaflets and advice sheets, for example, on dyspepsia (painful, difficult, or disturbed digestion), hiatus hernia (the protrusion of the upper part of the stomach into the chest cavity through the oesophageal hiatus because of a tear or weakness in the diaphragm) readily available for patients. Staff would discuss findings of the procedure with patients and provide nutritional advice where necessary.
- We spoke to a relative who had power of attorney and were told that doctors were open and honest with diagnosis and they found that they were involved in decision-making.
- There was a multi-faith prayer room available for patients on Laurel ward.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital.
- The Evergreen ward was a new therapy and nurse run rehabilitation ward for medically fit for discharge

patients and exercise classes were run in the afternoon for patients. This was well attended by patients and staff said they found patients made good progress in the rehabilitation process.

- Patients in the acute stroke unit had good access to occupational therapists, physiotherapists and speech and language therapists who were based on the ward. This ensured that service had being planned, delivered and coordinated taking into account patient's individual needs.
- Intentional rounding by care staff was completed throughout the patients' stay. This meant staff visited patients regularly for example; two hourly to check if call bells and a drink were in reach, if the patient required repositioning, if the patient had pain or had any other requests.

Learning from complaints and concerns

- From September 2015 to August 2016, there were 107 complaints about medical care services at the hospital and it took an average of 45 days to investigate and close complaints. This was not in line with the trust complaints policy, which stated that 90% of complaints should be closed within 25 days. Clinical treatment accounted for 37% of all complaints received, while admissions, discharge and transfers as well as values and behaviour of staff accounted for 12% and 13% respectively. At the end of August 2016 there were 16 complaints still open, 11 received in July, and five in August 2016.
- Clinical leads told us that they were aware of a backlog of complaints that breached the timescales of the trust complaints policy. The trust had complaints coordinators and weekly accountability meetings. Matrons were trained in complaints management and writing letters.
- Staff discussed complaints during team meetings to ensure action taken to improve the quality of care and learning opportunities were cascaded to staff.
- We saw evidence that learning opportunities were identified through investigating complaints. For example, there was a complaint about a grade three pressure ulcer; the patient had moved wards so it was difficult to investigate. This resulted in changes made which included, carrying out skin assessment when patients were admitted to the wards, while they were on the wards and upon discharge to ensure no pressure ulcers were present. Pressure ulcers prevention plans were to be audited monthly aiming for 100% competency with pressure ulcer prevention.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method, such as by telephone or email. Patients were informed about the right to complain further and staff encouraged patients to use the patient advice and liaison service.
- Staff gave friends and family cards to all discharges and patients were informed about PALS if a concern was raised.
- Patients knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas.

Are medical care services well-led?

Inadequate

We rated well-led as inadequate because:

- The leadership, governance and culture did not always promote the delivery of high quality person-centred care. Known concerns had not always been responded and acted upon. For example, during our last inspection, we identified issues with inadequate storage of medicines and lack of compliance with mandatory training. During this inspection, we still found poor practice in these areas. This meant that issues raised had not been addressed appropriately.
- The systems, processes and the operation of governance arrangements in place were not effective in terms of identifying and mitigating risks to patients. The National Early Warning Score (NEWS) was a system used by the trust to identify deteriorating medical patients. This system was not working effectively as NEWS charts were not completed in their entirety in seven records. The risk of patients suffering harm as a result of clinical deterioration was not being identified and escalated appropriately. This meant that there was not clear oversight on the deterioration of those patients.

Medical care (including older people's care)

- The governance system in relation to the management of risk did not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.
- Not all risks identified were on the divisional risk register and local wards did not have their own risk register.
- There was generally good leadership at a ward level within medical care, with evidence of effective communication within ward staff teams, but there was not always effective leadership from senior managers and clinical leaders as concerns raised were not always acted upon in a timely manner.
- Medical patients being cared for on non-medical wards were not always effectively managed. There was a policy in place for the management of patient transfers. However, this policy was not always effectively followed.
- Not all staff felt able to contribute to the ongoing development of their service. Staff said work pressures, due to higher patient dependencies, was an area of concern.
- There was poor oversight of the service, for example, medicine
- Clinical leaders, senior managers and the executive team were not always visible.
- Staff morale was generally quite low on some medical wards.
- There was a clear governance structure but there was limited evidence of learning discussed at key meetings and there was low attendance by some clinicians due to staff shortages.

However:

- Staff were committed to delivering good, compassionate care and were motivated to work at the hospital.
- Staff were proud to work for the trust and they were enthusiastic in their work.
- The trust had a leadership programme, which enabled senior staff to learn from each other's experience and share ideas on how they should be managing clinical areas.

Leadership of service

- Local leaders were visible and approachable and ward managers understood some of the challenges at a local level within the medical service.
- The trust had developed a leadership programme, which included options for accredited courses. We spoke with two senior nurses who confirmed they were on the programme and it enabled them to learn from each other's experience and share ideas on how they should be managing clinical areas.
- Consultants and senior staff raised concerns regarding decisions to move patients without prior assessment and evaluation.
- Staff reported that communication from the trust executive team was not always timely although they felt this had improved since the appointment of a new management team. However, staff on Evergreen ward said that the communication regarding the setup of the ward was poor and had received very little prior notice of the wards implementation and their reallocation to the ward.
- Staff found their managers friendly and supportive and had good training opportunities.
- Nursing staff across the medical wards felt well supported by the matrons. During our inspection, we observed matrons in various clinical areas communicating with both staff and patients.
- We observed that ward staff worked well together and supported each other. Staff across medical wards reported feeling pressurised by the bed management team. During our visit to the wards, we overhead several phone calls requesting updates of patient discharges. Ward managers felt that bed management was too much of a priority to the detriment of patient care.
- All staff were committed to delivering good, safe and compassionate care. They told us that they were proud to work for the trust.
- Staff said that the executive team were not always visible and did not visit the wards.

Vision and strategy for this service

- The trust's values were based on PRIDE which were:
  - Patients at the centre
  - Respect for everyone
  - Improve and innovate
  - Dependable
  - Empower
- Staff were aware of the vision and strategy of the trust. For example, out of 73 staff we spoke with, 62 could clearly articulate the vision and strategy of the hospital.

- The trust's strategic objectives were based on this vision and these objectives cascaded down to service and individual objectives for staff.
- Medical services had outlined key objectives to support the overall trust operation plan. These included the drive in improvement in reduction of length of stay and improved support for the care of the elderly.
- Senior staff within the medical services had clear visions for each of the specialities on how the services were to develop and move forward, this included opportunities to share learning across the specialities.
- Senior staff were aware they needed to attract doctors and nurses who had particular interests in their speciality. The recruitment programme was specific to the specialities needs, with matrons and ward sisters involved in the recruitment of staff.

Governance, risk management and quality measurement

- The service had a governance structure. However, there was no clear escalation processes from ward to board, and board to ward. Information was shared across the division, the trust quality and safety group and trust executive boards. We saw minutes from these meetings during the inspection with information disseminated to the multidisciplinary team.
- Although there was a governance framework to support the delivery of the strategy and good quality, it did not always promote the delivery of high quality person-centred care. For example, ineffective medication storage at recommended fridge temperatures were identified both during our last inspection and this inspection, which meant the trust, did not have adequate systems in place to rectify these issues.
- The systems, processes and the operation of governance arrangements in place were not effective in terms of identifying and mitigating risks to patients. For example, NEWS charts were incomplete in seven records looked at during our inspection. This meant that there was not a clear oversight on the deterioration of patients whose charts were not completed in their entirety.
- There were not robust arrangements for identifying, recording and managing risks in place. For example, there was lack of oversight of venous thromboembolism (VTE) assessments. The risk of patient harm as a result of not carrying out VTE assessments was not being managed on the divisional or corporate risk register. This meant that the trust's governance system in relation to the management of risk did not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment.
- Some patients moved to non-medical wards with no actions taken to mitigate risk. Even though the service had an escalation policy, there was no robust process in place to determine the criteria for patient moves.
- Three consultants from different medical wards expressed concerns with the movement of patients to other escalation wards without prior assessment and oversight. We could not be assured that the trust had embedded processes in place to determine the risk to patients prior to bed moves and following bed moves.
- The risk register highlighted risks across medical services and actions were identified which included a recruitment and retention strategy to mitigate the risk. Ward managers were able to tell us what the key risks for their wards were. However, not all risks identified were on the divisional risk register and local wards did not have their own risk register.
- There was an inconsistent approach to governance and risk management within the medical specialities. We found poor oversight of outcome measures, which included record management and management of bed moves.
- There was a clear governance reporting structure in medical services and the main governance and quality meeting was held on a monthly basis. During the meeting a review of the risk register, incident, infection, audits, complaints and feedback from services were undertaken.
- Each speciality held monthly clinical governance meetings. We reviewed the minutes of three meetings across the specialities and saw there was good attendance from the multidisciplinary teams. Adverse incidents, infection control, performance indicators and patient feedback and or complaints were reviewed.
- Minutes of the monthly medical services governance and quality group meetings showed that there were discussions and actions planned around safety and quality improvements, clinical effectiveness and patient experience. However, the action plan did not identify any outcomes or targets. This meant we were unclear of the oversight in relation to for example medicine management.

Medical care (including older people's care)

- Multidisciplinary team meetings were held regularly on each medical ward. There was evidence on wards that regular team meetings took place and minutes were cascaded to staff via email. There was also a copy of the minutes in a file on the ward for staff to read.
- Ward sisters held monthly meetings that included; a review of complaints and compliments, details of incidents including falls and medication omissions, clinical effectiveness audit results, staffing and recruitment, training and risks. We saw evidence of these meetings and found that they were structured and inclusive.
- We spoke with the ward managers across all medical services who demonstrated a good awareness of governance arrangements. This included incident reporting and undertaking audits.
- Trust board papers published in September 2016 showed that a visit had been undertaken to another trust to learn from their experiences. A new system had been put into place with the divisions being held to account for undertaking mortality reviews. A focus was being made on sepsis and the acting chief medical officer stated that the metrics should improve by November 2016.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

Culture within the service

- We spoke to staff that had been deployed from other wards to provide cover on the newly opened Evergreen ward. We asked about how staff were informed about the move and were told that some staff received text messages to inform them they had to move to a new ward and some were informed by email with very short notice given.
- Consultants spoke of the positive relationship with other consultants across the three hospitals. They confirmed an open policy regarding the sharing of views in relation to the planned reconfiguration of medical services.
- There was an open and transparent culture where staff were encouraged and felt comfortable about reporting incidents.
- Staff were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work and some staff we spoke with had worked at the hospital for a number of years.
- Teams worked collaboratively, with support and advice provided as necessary. On the wards, we observed senior staff mentoring junior staff in their tasks. Mentoring staff explained processes and procedures to ensure they understood the processes.
- Patients acknowledged a positive and caring ethos and were mostly happy with their care.
- Ward staff appeared to work together well and supported each other when short staffed.

Public engagement.

- Staff within medical services recognised the importance of gathering the views of patients and actively sought comments and feedback on the services provided.
- The NHS Friends and Family Test (FFT) gathered patient's views. We saw most comments were positive with most comments showing that staff were helpful and efficient. However, the results from August 2015 to July 2016 rated the service's response rate as worse than the England average of 26% at 17%. Senior staff confirmed they were aware of the low response rate and were looking at ways to improve this. There was an action plan in place to revise how the trust conducts and collates FFT in order to improve the response rate.
- The service had recently embarked on a plan to co-produce a refreshed patient and public engagement strategy with its communities and partners. We were told that the chief nurse was leading a programme of work to build stronger and more dynamic collaboration with patients and the public, developing the way the trust works and communicates with the communities it serves. However, staff said they were unaware of the strategy or of its implementation.
- The service worked with a range of voluntary agencies including Age UK, the local community trust, Alzheimer Society and Healthwatch and gained informal feedback from these stakeholders. We saw a record of engagement with partners up to September 2016.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Staff engagement

Medical care (including older people's care)

- Staff engagement was primarily through team meetings, training events and email and intranet services.
- The staff survey identified some staff had personally experienced or had witnessed bullying or aggressive behaviour. Staff we spoke with said that although they were aware of the staff survey results they had no evidence regarding any bullying. However, they confirmed they felt supported by their local leaders and would not hesitate to make the relevant concern in line with the trust's whistleblowing policy.
- Some staff reported low morale across medical wards and the discharge lounge due to staffing levels, work pressures and high patient dependencies. There was high level of staff sickness rates across the service which included the medical high dependency short stay unit and the acute stroke unit. This was reflected in the rotas seen.

Innovation, improvement and sustainability

- The hospital had joined with another nearby NHS trust to act as a satellite service in cancer treatment, which allowed patients to be treated closer to home.
- Staff within medical services recognised the importance of gathering the views of patients and actively sought comments and feedback on the services provided.
- Recruitment events had been planned for the next 12 months rotating around the trusts three sites. There was work in place aimed at increasing the number of staff on their books and fortnightly recruitment events around the trust had been planned.
- The trust had implemented the sepsis box to improve and maintain the management of sepsis within the hospital. These were located on the resuscitation trolleys across medical wards and were readily available for patient use.
- A dedicated helpline was available for patients who were receiving treatment for cancer.
- Following the last inspection the trust had made improvements in the following:
  - The reporting of incidents to ensure lessons learnt were cascaded to staff.
  - A review of the referral process to ensure the service was meeting its18 week pathway in accordance with national standards.

Surgery

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

Information about the service

Surgery services provided by Worcestershire Acute Hospitals NHS Trust are located on the main hospital site and three other hospital sites, those being The Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital.

The Alexandra Hospital and Kidderminster Hospital and Treatment Centre were visited as part of this inspection process and each is reported upon separately. Evesham Community Hospital was not visited as part of this inspection. Services on all four hospital sites are run by one management team. As such they are regarded within and reported upon by the trust as one service, with some of the staff working at all sites. For this reason it is inevitable there is some duplication contained within the reports.

The Trust provides services to a resident population of 550,000 people in Worcestershire. This report relates to surgery services provided at Worcestershire Royal Hospital (WRH) which consists of five surgical wards, plus a surgical clinical decisions unit (SCDU) and eight theatres to provide planned (elective), emergency and day case surgery.

There are 131 surgical beds over five wards, Beech A, Beech B, Trauma and Orthopaedic ward, Severn ward and Chestnut ward. The SCDU has 13 trolleys/beds which provide interim care for patients either referred by their GP or admitted via the emergency department, requiring an urgent surgical clinical assessment. Surgical service provision includes; general surgery, orthopaedics, trauma care, vascular surgery, breast surgery, ear, nose and throat (ENT) and oral and maxillofacial surgery and head and neck surgery.

From April 2015 to March 2016 there were 19,878 spells (a spell refers to a continuous stay of a patient using a hospital bed), with 50% day surgery, 20% elective spells and 30% emergency cases.

We visited all surgical services as part of this inspection, and spoke with 42 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists and ward managers. We spoke with nine patients, and reviewed ten patient records, including medical and nursing notes.

The Care Quality Commission carried out an inspection at Worcestershire Acute Hospitals NHS Trust in July 2015. Overall the surgical service was found to be requires improvement.

Surgery

Summary of findings

Overall we rated the surgery service as requires improvement.

We rated surgical services as requires improvement for safe, effective and responsive, good for caring, and inadequate well-led because

- Patient outcomes were generally below the England averages and not all staff were aware of patient outcomes relating to national audits or performance measures.
- The trust had mixed performance for national Hip Fracture Database audit and the National Emergency Laparotomy Audit.
- There was no access to 24-hour Interventional radiology services.
- Not all patients had been reassessed 24 hours after admission for venous thromboembolism (VTE).
- There was variable compliance with hand hygiene and the use of personal protective equipment.
- Medical notes were not always locked away safely.
- There was a high number of medical and nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts.
- Not all staff had completed mandatory training or received an annual appraisal.
- The admitted referral to treatment time (RTT) was consistently below the England average of 80%.
- The number of cancellations of operations was higher than the national average.
- There was insufficient capacity in emergency theatres.
- There were high levels of unplanned medical patients admitted onto the surgical wards, resulting in some cancelled operations.
- Patient were not always offered a choice about where they were discharged to for continuing care.
- Some staff were not aware of the plans for the county wide management of emergency surgery in inpatient services. However, the trust told us this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service.
- There was a countywide strategy for surgical services but not all staff were aware of it.
- There was a lack of effective risk management.
- Staff told us there was disengagement between consultants, department managers and the divisional leaders.
- Staff felt pressured into accepting patients onto the wards when they were already full.

However we found:

- There was a culture of incident reporting and staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate and there were good emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.
- Treatment and care were provided in accordance with evidence-based national guidelines.
- Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures to keep people safe.
- There was a good consent process in place.
- The service had an effective complaints system in place and learning was evident.
- There was support for people with a learning disability and reasonable adjustments were made to the service. An interpreting service was available.
- Staff were caring and compassionate to patients' needs. Patients spoke highly of the care they had received.
- Patients' pain, nutrition and hydration was appropriately managed.
- The governance framework had improved.
- There were regular staff meetings at all levels and information was shared with staff.
- There was evidence of patient and public engagement.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There were a high number of vacancies for nursing staff in surgery. Safe staffing levels were being achieved by the use of bank and agency staff.
- Generally staff followed the trust policy on infection control, although there was variable compliance with hand hygiene and the use of personal protective equipment.
- Patient medical notes were not always locked away safely.
- White electronic boards displaying patient details were visible to all visitors to the wards, therefore we were not reassured that patient confidentiality was maintained at all times.
- National early warning scores were used to identify sick patients but these were not always accurately documented and were inconsistently used.
- Not all staff had completed mandatory training.
- Safeguarding children training was below the trust's target.
- Some patients had not been reassessed 24 hours after admission for risk of developing a venous thromboembolism.

However:

- Staff were encouraged and confident to report any incidents, and serious incidents were discussed at team meetings. Staff were aware of the importance of duty of candour.
- We observed the Five Steps to Safer Surgery checklists being completed appropriately.
- There was access to appropriate equipment to provide safe care and treatment.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care. Some of this information was displayed within the wards and clinical areas.
- Patient care records were appropriately completed with sufficient detail.
- Nursing and medical handovers were well structured within the surgical wards visited.
- The environment was visibly clean. Equipment was visibly clean with an 'I'm Clean' sticker placed on to it.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- There were 21 serious incidents reported for Worcestershire Royal Hospital (WRH) via the Strategic Executive Information System (STEIS), from October 2015 to September 2016. The most common themes related to pressure ulcers.
- There was one never events reported at WRH from August 2015 to August 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The reported never event related to a patient undergoing surgery following a right fractured hip and the left groin was prepared for a nerve block. The error was realised on commencement of the surgery and was corrected. Staff were aware of the never event and were able to discuss actions taken which included a process of 'stop before you block', to ensure the correct side is being prepared.

- During the last inspection it was reported that from April 2014 to May 2015 there had been 18 grade 3 pressure ulcers. During this inspection nine pressure ulcers had been reported from September 2015 to September 2016. This meant that measures the trust had undertaken to reduce the number of pressure ulcers had been successful. For example, the introduction of turning charts for patients who are unable to reposition themselves in bed.
- Staff were able to describe changes that were made as a result of learning from incidents. For example, when a patient developed a pressure ulcer, the patient refused to have a specialist mattress, lessons learnt included educating patient to the benefits of a specialist mattress and involving the link nurse in care needs.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour legislation. Nursing and medical staff were fully aware of the duty of candour and described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. We saw evidence that the duty of candour had been applied following the never event.
- We saw each surgical speciality held regular mortality and morbidity meetings and individual cases were discussed and lesson learnt such as checking discharge medication, blood tests were are carried out promptly and to utilise the support from specialist nurses in patients care.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Information was displayed in the ward corridors for patients, relatives and staff. This included information about patients' falls, pressure ulcers and infections. Staff we spoke with were aware of the data and used this as a safety indicator of the care they provided and where risks had been minimised.
- From September 2015 to September 2016, it was reported for the trust's surgical division, there were nine pressure ulcers, nine incidents of falls, and 13 reported urinary catheter related infections. There were no new MRSA infections in the past year.
- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based. From July 2015 to July 2016, VTE compliance was 96%. However, we found from the ten sets of notes reviewed, two patients had not been reassessed 24 hours after admission for VTE which was not compliant with 2010 guidance from the National Institute for Health and Care Excellence (NICE) for reducing the risk of venous thromboembolism in adults. We brought this to the attention of senior staff during the inspection. In a response provided by the trust on 11 January 2017 after this was raised as a significant concern, the trust told us matron ward visits would include checks of patient documentation to ensure assessments were carried out on all patients. We saw a specific action plan which included training for staff on completion and recording of VTE assessments and a review of funding to recruit specialist VTE nursing.

Cleanliness, infection control and hygiene

- At the time of our inspection, the environment and equipment in the ward and theatres were visibly clean and tidy.
- Staff had received training about infection prevention and control during their initial induction and during annual mandatory training. We saw that 85% of nursing staff had completed their training in infection prevention and control, against a trust target of 90%.
- There was a specific cleaning schedule in place. Cleaning staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor and we saw evidence that regular checks had been completed.
- We observed that most staff followed the trust's policy regarding infection prevention and control. This included being 'arms bare below the elbow', however not all staff were compliant with hand washing. For example we observed nursing and medical staff moving from one patient to another without any hand washing or using the alcohol gel in between. This was raised with senior management at the time of the inspection, who would remind staff of the need for handwashing.
- Hand hygiene gels were available throughout the wards and theatres. We observed all staff using alcohol hand gel when entering and exiting the wards.
- Personal protective equipment (PPE), such as gloves and aprons were available in sufficient quantities but were not always used appropriately. For example we observed staff attending to one patient wearing gloves and aprons, then approaching another patient to turn off their call bell and did not change their PPE or adhere to the hand hygiene policy.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, sharps bins and the bins were not overfilled.

- We saw audits of environmental cleaning and decontamination of clinical equipment from May 2016 to August 2016 had been completed with an average compliance score of 83%. Actions taken included feedback to the cleaning teams, laminating posters so they could be wiped and removal of damaged equipment.
- There we no reported surgical site infection at the hospital for hip and knee surgery from July 2015 to June 2016.
- From August 2015 to August 2016 there had been no reported cases of MRSA and one reported case of Clostridium difficile on the surgical wards, which was fully investigated.

Environment and equipment

- The ward and theatres were spacious and well-lit and corridors were free from obstruction to allow prompt access.
- Resuscitation equipment, for use in an emergency was checked daily, and documented as complete and ready for use. Although not all emergency drugs were stored securely or protected with a tamper evident label or seal to provide visible evidence that they were safe to use. We raised this with the trust management during our inspection, who would review the storage of medicines on emergency trolleys.
- There was a difficult airway trolley in theatres. This equipment was checked daily which meant staff could effectively respond in an emergency situation.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans.
- Electrical appliances and equipment we checked during the inspection had been electrical equipment tested to ensure they were safe to use and each had a stickers with appropriate dates to show this had taken place.
- We saw that hoists and firefighting equipment had been regularly checked and serviced.
- The airflow systems in theatres were revalidated regularly by an external organisation and met standards set out in the national guidance, Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises. Data provided by the trust showed theatre ventilation validation and maintenance had taken place in October 2016 with an action plan in progress to ensure compliance for example painting the overhead canopy, replacing the vents and reviewing the light and theatre doors.
- Some equipment such as the anaesthetic machines had been standardised to improve safety. The same machines were used in every anaesthetic room and operating theatre throughout the trust.

Medicines

- The pharmacy department was open between 9am and 5.30pm with an out of hour's on-call pharmacist service.
- The pharmacy team visited all wards each weekday and a pharmacist was available out of hours. The pharmacist recorded information on the prescription chart to help guide ward staff in the safe prescribing and administration of medicines.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics. We saw records of the daily checks of ambient temperatures in the medicines storage room had been routinely completed.
- Medicines that required refrigeration were kept at the correct temperature. We saw records of the daily checklists of ambient fridge temperatures. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported. Staff were aware of what action to take if the fridge temperature was outside safe parameters. On a few occasions when the fridge temperature had exceeded the temperature range this has been reported and resolved.
- Drug cupboards were left unlocked in the anaesthetic rooms, whilst theatres were in use to allow easy access. A risk assessment for this had been undertaken by pharmacy. The controlled drug cupboards were locked at all times.
- Controlled drugs were stored in a locked unit and the keys held separately from the main drug keys. We reviewed the controlled drug cupboards which were tidy and did not hold any other equipment or medicines in these cupboards.
- Entries in the controlled drug register were made correctly regarding the administration of drugs to the patient and were signed appropriately. New stocks were checked and signed for, and any destruction of medicines was recorded.

- Nursing staff wore a red apron to indicate they were administering medicines to alert staff not to disturb them to prevent drug errors.
- There was a medicines management policy which included information on safe administration of controlled drugs and administration of medicines, which staff could access via the hospital intranet.
- All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Records

- During the last inspection it was reported that the quality of medical record keeping was found to be variable. During this inspection we reviewed ten sets of nursing and medical records and found they were in good order and information was easy to access.
- Records included details of the patient's admission, risk assessments, pre assessments forms, treatment plans, and records of therapies provided. Records were legible, accurate, and up to date.
- The nursing and medical notes were stored away from public view, for example behind the nurses station in notes trolleys, but these were not always locked, therefore we were not always assured of the security of medical records at all times.
- Daily care records such as fluid balance records and care plans were stored in folders at the patient bedside. We looked at samples of records which were fully completed, legible with entries timed, dated and signed.
- White electronic boards were used to display patient name and location on the wards, which included some care and treatment information. These were visible to staff and visitors to the ward, therefore we were not reassured that patient confidentiality was maintained at all times.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The nursing and medical staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- The trust reported in September 2016, that 95% of medical staff and 100% of nursing staff had up to date training in adult safeguarding levels one and two. However, less than 10% of medical staff and 23% of nursing staff had completed safeguarding children training at levels one and two. The trust's target was 90%.

Mandatory training

- Mandatory training was provided for staff and included for example infection control, fire, moving and handling and health and safety. Some training was delivered via face-to-face sessions and others were available via the electronically.
- There was an induction programme for all new staff and staff that had attended felt that the programme met their needs.
- The trusts training record for September 2016 showed that for the surgical division, 70% of nursing and 63 % of medical staff had completed their mandatory training against a trust target of 90%. This was similar to last year.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained. For example all elective patients attended a preoperative assessment clinic and the trust used the five steps to safer surgery checklist, in line with national guidelines.
- We saw audits of the five steps to safer surgery were 100% compliance from August 2015 and August 2016. Observational audits had also been carried out which highlighted the need to improve staff engagement and that all theatre staff involved in the surgical procedure should be present at team brief.
- Patients for elective surgery attended a preoperative assessment clinic prior to the day of their operation. During the assessment any required tests were undertaken, for example, MRSA screening and any blood tests. If required, patients were reviewed by an anaesthetist and had a dedicated appointment. The nurses completed a work list on line for anaesthetists to review raising any concerns or additional advice. The pre-operative nurses would follow this up and contact the patient directly if required.

- Risk assessments were undertaken in areas such as venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate any identified risks.
- The National Early Warning Score (NEWS) was used to identify deteriorating patients in accordance with NICE clinical guidance CG50.
- Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, indicating a deterioration and members of staff were aware of these. We reviewed ten patients' notes and found NEWS charts were being used to record patients vital signs. Staff were aware when to escalate a high score.
- A trust wide audit carried out from August 2016 to November 2016, found NEWS were not always accurately documented, ranging from 77% to 100%. The trust had an action plan in place to improve accuracy of NEWS, this included staff training, competency assessments, monthly audits with results reported to senior staff.
- The trust had an outreach team and hospital at night team who provided clinical support with deteriorating patients.
- During the last inspection, it was reported that the Waterlow tool was sometimes incomplete. The Waterlow tool is used to estimate risk for the development of a pressure ulcer. During this inspection, we reviewed ten sets of notes and found the Waterlow tools were being used and 'Intentional rounding' implemented to check on all patients at set times to assess and manage their fundamental care needs.
- Staff told us they were aware of the trust sepsis policy and some had training in sepsis awareness.
- There was 24 hour access to emergency surgery teams, including theatres, and doctors. During the night, there was a senior house officer who covered the surgical wards who was supported by the on call consultant for surgery.
- We observed a patient being admitted to the theatre area for surgery. We found staff introduced themselves to the patient; all checks were carried out including identification of patient and consent form.

Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool.
- The surgical directorate used an acuity tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements to determine appropriate staffing levels. There was a staffing review in January 2016, when amendments and adjustments to staffing levels were made.
- During the last inspection, there was a 13% vacancy rate in theatre. This had improved slightly as during this inspection the vacancy rate was 10%. The overall nursing vacancy rate within the surgical division was 24%. Vacancies were on the surgical risk register, actions included the use of bank and agency and monthly reviews of recruitment and vacancies.
- The sickness rate in September 2016 was 4% against a trust target of 3.5%. This was better than our last inspection, when the average sickness rate for nursing staff in the surgery team was 4.9%.
- From May 2016 to November 2016, there were 27 reported incidents of staff shortages, some incidents were recorded as unplanned staff absence due to sickness or agency staff cancelling at short notice. Lessons learnt included the need to forward plan.
- From May 2016 to October 2016 the trust reported 133 unfilled nurse shifts and 79 unfilled healthcare assistant shifts.Ward managers were supernumerary and would help with unfilled shifts and workloads. Staff told us that nursing staff were moved from one wards to another to help maintain patient safety.
- The planned and actual staffing numbers were displayed on the wards visited. Staffing levels were appropriate to meet patients' needs during our inspection.
- Staff worked extra shifts and bank and agency staff were being used to cover nursing vacancies. Some agency staff were being blocked booked for shifts in advance. This assisted with safe staffing levels and continuity of care. We saw evidence that all new agency staff had an induction checklist completed to ensure that they become familiar with the ward layout and processes.
- We observed two nursing handovers that were well structured and used electronic information or paper. The information discussed included patients going to theatre, requiring appointments for investigations, patients being discharged, pain management, medicine

and Deprivation of Liberty Safeguards (DoLS) assessments. The handovers occurred outside the bays for all staff on duty ensuring patient privacy, dignity and confidentiality were maintained.

Surgical staffing

- During the last inspection, staff had reported a lack of experienced doctors to cover the trauma and orthopaedic service during out of hours (weekends and nights). At this inspection, doctors and consultants said they had sufficient cover for their specialities. Staffing levels were appropriate to meet patients' needs during our inspection and agency and locum doctors were used to fill shifts.
- In September 2016, the trust reported a 3% consultant vacancy rate and a 27% vacancy rate for other medical staff grades. Medical staffing vacancies were on the surgical risk register, actions included the use of long term locums and changes to rotas to improve recruitment.
- The records provided by the trust showed that the medical staffing levels were similar to the national average, with 49% for consultant cover which is higher than the England average of 44%. Middle career group (doctors who had been at least three years as a senior house officer or a higher grade within their chosen speciality) was at 12% which was higher than the England average of 10%. Registrars were 24% which was lower than the England average of 35%, whereas junior doctors were 16% which was higher than the national England average of 11%.
- We observed the doctors handover which was well attended, consultant led and appropriate information was shared. For example new admissions overnight, patients waiting to be seen in the emergency department and patients of concern on the wards. The consultant discussed the workload and allocated actions.
- Doctor's handover ward rounds occurred daily on each ward. There was good interaction between doctors and nursing staff.
- Surgical consultants worked weekends and carried out ward rounds to ensure that there was provision of consultant led care and decision making. There was consultant cover for emergencies, 24 hours a day.
- Junior doctors had specific personal development plans, a mentor and clinical support. They told us they felt supported and the consultants were accessible, approachable and available when required.

Major incident awareness and training

- Staff were aware of the major incident policy in place relating to all departments within the trust including surgical services.
- Some staff told us there had been fire evacuation exercises and were able to explain the actions to be taken.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- The national Hip Fracture Database audit showed the trust had a mixed performance against the England averages.
- Data from the National Emergency Laparotomy Audit 2015 showed the trust had mixed performance against the England averages.
- There was no access to 24-hour Interventional radiology services.
- Less than half of nursing and medical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff were unaware of results from national audits and any action plans.
- Not all staff had received an annual appraisal.

However:

- The trust participated in national and local audits, for example the Patient Reported Outcome Measures (PROMS) which overall showed the trust was similar to the England averages for PROMS measures for hips and knees.
- Policies and procedures were accessible, and staff were aware of the relevant information. Care was monitored to demonstrate compliance with standards.
- Patients' pain, nutrition and hydration was appropriately managed.
- The surgical service had a consultant-led, seven day service, with daily consultant ward rounds.

- Generally, staff had awareness of the MCA and DoLS.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health and social care needs (clinical needs, mental health, physical health, and nutrition and hydration needs). Patients' care and treatment was planned and delivered in line with evidence-based guidelines for example nutritional and hydration needs, falls assessment and consent.
- Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice. Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- There was participation in relevant local and national audits, including clinical audits such as surgical site infections and environmental audits.
- The use of peripheral intravenous cannula care bundle were used to improve the quality of care. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. Multidisciplinary teams work to deliver the best possible care supported by evidence-based research and practices, with the ultimate outcome of improving patient care.
- The pre-operative assessment clinic assessed patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. For example MRSA screening and blood tests.

Pain relief

- Our observation of practice and review of records confirmed that pain was assessed and managed effectively.
- Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner. Pain management for individual patients was discussed at handovers as required.
- There was a dedicated pain team to support patients with epidurals who were being cared for on the surgical wards. The acute pain service was consultant led with the support of three countywide acute pain nurses.

Nutrition and hydration

- Patient's nutrition and hydration status was assessed and recorded using the Malnutrition Universal Screening Tool. During the last inspection it was reported that this was not consistently completed for all patients. During this inspection we found up to date MUST assessments in all the patients notes we reviewed.
- If a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietitian.
- In all 10 records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- We observed a lunch time on Severn ward, there was good interaction between staff and patients and staff ensured patient were comfortable and good reach their meal trays. Patients were encouraged to eat their meals.
- Depending on the type of surgery they were undergoing, some patients for elective procedures were given a pre-operative drink. The purpose of this drink was to aid the patient's recovery following their operation.

Patient outcomes

- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme, the National Joint Registry and the National Emergency Laparotomy Audit.
- During the last inspection it was reported there was no evidence on how information was cascaded and shared at all levels of the organisation to improve care and treatment and people's outcomes. During this inspection we found staff were still unaware of patient outcomes following audits and this information was not shared with staff.
- Data from the National Emergency Laparotomy Audit 2015 showed the trust had mixed performance. The audit is rating red (0-49% compliance), amber (50-79% compliance) and green (80 to 100%). The hospital had two red rated, four amber rated and five green rated. The green rated included CT scans reported before surgery and a consultant surgeon present in theatre,

and the red rated were no review by a consultant within 12 hours of admission and no assessment for patients over 70 years old by a Medical Consultant for the care of older people.

- During the last inspection it was reported that the National Emergency Laparotomy results for 2014 showed a non-compliance to provide a sustained 24-hour Interventional radiology service which is essential for units providing emergency general surgery service. During this inspection we found there was still no 24-hour Interventional radiology (IR) service available and this had been on the risk register since 2014. The consultant interventional radiologists provided partial cover on an informal basis. However, as this was an informal arrangement, it could not be relied upon entirely and the lack of a 24-hour IR service was still a major risk. The trust told us a business case for additional IR resources had been submitted but we were not aware of the progress of this case.
- The hospital participated in the National Hip Fracture Database which is part of the national falls and fragility fracture audit programme. A review of the 2015 report indicated that mortality rate was 8.2%, which falls within expectations.The proportion of patients having surgery on the day of or day after admission was 60%, which does not meet the national standard of 85% but has improved on the previous year which was 52%. The perioperative surgical assessment rate was 90%, which does not meet the national standard of 100%. We saw a corrective action plan was in place which included, prioritising fracture neck of femur cases on the trauma lists, daily report on the achievement of the 36 hours targets, a business case for additional weekend trauma sessions for both the Alexandra Hospital and the Worcestershire Royal Hospital.
- PROM audit measures health gain in patients undergoing hip and knee replacement and groin surgery in England. The patient related outcome measures for the hospital for groin hernia showed fewer patients' health improving and more patients' health worsening than the England averages. The Oxford hip score and Oxford knee score were in line with the England averages.
- The data from the National Bowel Cancer Audit 2015 showed that 69% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was the same as the national average. The 2014 figure was 80%. The 90 day and two year post-operative mortality rates were within expected range. The unplanned re admission rates were within the expected range.
- The average length of stay for surgical elective and non-elective patients from April 2015 to March 2016 was 3 days and 5 days respectively. This was similar to the England average.
- During the last inspection, there was delays of transfer of patients requiring emergency acute abdominal surgery from the Alexandra Hospital of up to 10 hours which meant their condition could potentially deteriorate further prior to and during transfer for treatment. During this inspection we found this had improved as most emergency acute abdominal surgery cases were admitted directly to Worcestershire Royal Hospital, where the surgery would take place.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a specific induction programme for all staff. Staff that had attended the induction programme told us this was useful. The induction programme included orientation to the wards, specific training such as fire safety, infection control and manual handling as well as awareness of policies.
- Nursing staff (both agency and permanent) felt well supported and adequately trained within their departments.
- Junior doctors within surgery reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Some healthcare assistance within theatre had completed specific competencies to enable them to assist staff in theatres.
- During the last inspection it was reported that appraisal rates were below the trusts target of 85%. During this inspection we found, appraisal rates for July 2016 were still below the trust target at 80% for all staff working within the surgical division.
- Staff told us there was training opportunities for personal development and to enhance their skills such as cannulation, catheterisation and intravenous therapy.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment and mostly worked collaboratively to understand and meet the range and complexity of people's needs.
- Patient care on surgical wards was supported by teams from a variety of disciplines including physiotherapists, dietitians, pain team and pharmacists.
- During the previous inspection staff reported there was lack of support from medical staff responsible for the care of medical outliers (these are medical patients admitted to surgical beds when beds on medical wards were not available). During this inspection, on review of notes and discussion with staff we found that medical outliers were seen regularly and staff could access medical staff for advice when required.
- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported and that their contribution to overall patient care was valued.
- Staff could access the learning disability lead, critical care outreach team, pain management team, social workers and safeguarding teams who were able to provide advice and support to the surgical teams.
- We observed a good working relationship between ward staff, doctors, and therapists.

Seven-day services

- During the last inspection it was reported that on occasions daily ward rounds did not always occur due to lack of medical cover and these were not reported as incidents. disengaged.
- Sufficient out of hour's medical cover was provided to patients in the surgical wards with on site and on call consultant cover. Consultants could be contacted out of hours by junior staff if required.
- Theatres, anaesthetics, and recovery had staff on duty out of hours and at weekends to cover emergencies.
- There were imaging, pharmacy, pain teams and physiotherapy services were available at weekends and an on call service out of hours.
- During the last inspection, there was no access to 24 hour intervention radiology service. During this inspection, this was still the same although a business case had been submitted to address this.

Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff said they had good access to patient related information and records whenever required.
- Staff used printed sheets with included details of each patient's current diagnosis and care needs to handover care between practitioners at each shift.
- Discharge summaries to GPs were either electronic or paper copies and the patient was given a paper copy.
- We observed on-going care information was shared appropriately at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The records for August 2016 showed that within surgery, 44% of medical staff and 37% of nursing staff had received training in MCA and DoLS.
- Staff told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- Consent to care and treatment was obtained in line with legislation and guidance, including the MCA.
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- We saw one DoLS in place which was completed correctly and the patient's family had been informed and were involved in the patient's care.
- The hospital had an up to date policy on consent for surgical treatment.
- Staff understood consent, decision-making requirements, and guidance. The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who

were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic.
- All consent forms we saw were for patients who were able to consent to their operation or procedure and they were completed in full (they contained details of the operation or procedure and any risks associated with this). Patients were also able to have a copy if they wanted.
- There were no consent forms available in other languages. Interpreter services were available.
- Consent for surgery was generally taken from patients in the outpatients department.

Are surgery services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients' needs. Patients spoke highly of the care they had received.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- Patients were kept up to date with their condition and how they were progressing.
- Information was shared with patients and their relatives and opportunities to ask questions.

However:

- The NHS Friends and Family test response rates were lower than the England average.
- Privacy, dignity and confidentiality was not always maintained.

Compassionate care

- We saw staff respected patients' privacy and dignity during personal care, for example, staff pulled curtains around the bed space. However, staff told us on occasions patients were nursed in the corridor and screens were used, but this did not always maintain their confidentiality, privacy and dignity. During the inspection, we did not see any patients nursed in the corridor or treatment areas.
- Patients we spoke with told us that staff treated them with respect.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Comfort rounds (where nursing staff regularly check on patients) were undertaken and recorded.
- From September 2015 and August 2016, the Friends and Family Test, had a 22% response rate, which was lower than the England average of 29%. Over 90% of patients would recommend the hospital to friends and family.
- We observed one patient was encouraged to make a call home using the ward phone as the patient was concerned about arrangements at home. The nurse stayed with the patient during the call to offer reassurance.
- We received positive comments from the patients and relatives we spoke with about their care. Examples of their comments included 'the consultant's secretary is always helpful, very caring and rings back when she says she will', 'the anaesthetist gave me a choice of anaesthetics and helped me to decide which was best for me' and 'the nurses are so lovely, always kind and helpful'.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. Patients and relatives had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.

Emotional support

- Clinical nurse specialists were employed by the hospital to provide emotional support and advice to patients, such as stoma care.
- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.

- Staff had access to an on call chaplain and other spiritual advisors could be arranged to meet patients' needs.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The admitted referral to treatment time was consistently below the England average of 80%, in all specialities at 68% apart from ophthalmology which was 86%.
- The number of operations cancelled and not treated within 28 days was 14%. This was higher than the national average which was 6%.
- There were high levels of unplanned medical patients admitted onto the surgical wards, resulting in some cancelled operations.
- There was insufficient capacity in emergency theatres.
- Patients were sometimes nursed in the corridor or treatment rooms on the wards, although we did not see this during our inspection.
- Patients were not always offered a choice about where they were discharged to for continuing care.
- Some information leaflets and consent forms were only available in English.

However:

- Service planning generally met the needs of the local people and the community.
- The length of stay for patients was similar to the national average.
- There was support for people with a learning disability and reasonable adjustments were made to the service provided.
- Arrangements were in place to support patients living with dementia.
- An interpreting service was available and used.
- Complaints systems were effective.

Service planning and delivery to meet the needs of local people

- The service generally understood the different needs of the people it served and acted on these to plan, design and deliver services.
- The service generally planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible. Wherever possible accommodation was provided that was gender specific, and ensuring the environment and facilities were appropriate and required levels of equipment were available promptly.
- The needs of the local population had been identified and taken into account when planning services. Shortfalls had been identified, such as provision for unplanned medical patient admissions. During the last inspection, the high demand for medical beds was impacting on the efficiency of the surgery services. During this inspection, we found this issue continued and had not been resolved. This was documented on the surgical risk register. However, there did not appear to be robust plans in place to resolve this.
- From April 2015 to March 2016 the average length of stay for surgical elective and non-elective patients at the trust was similar to the England average.
- The service monitored the use of its theatres to ensure that they were responsive to the needs of patients. The average theatre utilisation from June 2016 to August 2016 was 80%.

Access and flow

- During the last inspection, some patients were not able to access services for assessment, diagnosis or treatment when they needed to. There were frequent delays or cancellations. The number of patients trust wide whose operation was cancelled on the day of surgery and were not rebooked to be treated within 28 days was 20% in 2015. During this inspection, 14% of patients had operations cancelled on the day of surgery compared to the England average of 6%. Staff told us this was mainly due to bed capacity and there was no defined action plans in place to improve this.
- During the last inspection, it was reported that medical outliers had an impact on bed capacity and were not always reviewed by the medical teams. During this inspection, following a review of notes and discussion with staff we found that medical patients were reviewed regularly. Although this high number of medical outliers on the surgical wards was still having an impact on bed capacity, which meant operations were cancelled as beds were not available.
- During the last inspection, it was reported that the theatre dedicated for emergency surgery had

insufficient capacity to meet the increasing workload resulting in delays to the treatment of emergency surgical patients. During this inspection we found this was still the same, although it was identified on the theatre risk register, there did not appear to be any plans in place to mitigate the risks.

- During this inspection, one patient with a fractured neck of femur waited four days before having surgery due to lack of theatre capacity. During the inspection we raised this with the hospital management team who commenced an investigation and completed an incident form.
- From September 2015 to September 2016, the trust's admitted referral to treatment time within 18 weeks (RTT) for surgery was 68% which was worse than the England average of 80%, apart from ophthalmology which was better at 86%. Although this was on the surgical risk register we did not see any action plans to improve waiting times.
- There was increased waiting times for patient needing urgent elective angioplasty, which is a procedure used to widen blocked or narrowed blood vessels, due to limited access to interventional radiology, this was on the surgical risk register. As of November 2016, eight patients had waited over 18 weeks for this procedure. Action plans included weekly monitoring of waiting lists, working closely with radiology to reduce the waiting times and a harms review of patients waiting longer than 26 weeks.
- During the last inspection, patients and their relatives were not always offered a choice of where continuing care in the community would be provided which was sometimes located a long distance away from family and friends. During this inspection we found this remained the same and there did not appear to be any plans in place to address this.
- Patients could be referred by their GP directly to the surgical clinical decision unit (SCDU). Patients would be assessed, treated and either admitted or discharged direct from SCDU. If a patient was critically unstable or required immediate emergency management, they may be transferred to the emergency department.
- From September 2015 to September 2016, there have been three reported occasions when patient have been nursed in theatre recovery overnight due to lack of bed capacity. Patients were prioritized the following day to be moved onto a ward. During this inspection, we did not see any patients being nursed in recovery overnight.
- Staff told us on occasions, patients were nursed in the corridor on the ward or a treatment room. These areas were not designed to care for patients overnight and housed equipment that staff would use frequently during their shifts which disturbed the patients. Screens were used in the corridors but this did not always maintain their confidentiality, privacy and dignity. During the inspection, we did not see any patient nursed in the corridor or treatment areas. There had been 19 reported incidents, of patient nursed in corridors on the surgical wards from February 2016 to November 2016.
- The average length of stay (LOS) for both elective and non-elective treatment at the trust, were similar to the England average LOS.
- An on call theatre team facilitated emergency surgery. Consultants in each speciality were on call at night and weekends and therefore could facilitate emergency procedures if necessary.
- From March 2015 to February 2016 the risk of readmission following surgery at the trust was better than England average for both elective and non-elective surgery.

Meeting people's individual needs

- Surgical services were planned to take into account the individual needs of patients.
- Staff told us they had link nurses for specific areas, for example infection control and dementia. The link nurses were able to support staff and share information.
- There were arrangements in place to respond to patients with special needs, such as the patient would be offered longer pre-operative assessment appointments and carers could stay with the patient longer on the wards.
- Some wards had a dementia box which contained some aids, games and a computer to access black and white films, games and music. Staff said these helped in caring for the patients living with dementia.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Staff who worked in pre-assessment advised patients on healthy weight loss, alcohol intake and smoking cessation where required and gave patients information on how to get advice and support.

- Each patient that attended pre-operative assessment was given a green plastic bag with specific information relating to their surgery such as blood transfusion, physiotherapy and after care.
- Patient information leaflets were available in all areas. Leaflets contained information such as wound care, pain management and skin care. Leaflets were not available in other languages.
- Patients told us call bells were answered promptly, that staff were kind and caring and they would be happy for their family to come to the hospital for treatment. During our inspection, call bells were being answered promptly.
- Theatre staff arranged for carers to accompany the patient to theatre where they had specific needs such as a learning or sensory disability.
- There was a prayer room for use by patients and their families.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly.
- Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- Literature and posters were also displayed within the ward areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- Notice boards on the wards included 'You said' 'We did', in response to patient comments. For example on one ward patient complained about the toast being cold and staff had purchased a toast warmer in response.
- From April 2015 to March 2016, the surgical division received 203 complaints; complaints were discussed at the surgical quality governance meetings. The themes were communication with patients and relatives and staff attitudes. Actions taken included implementation of communication training for all staff.

Are surgery services well-led?

Inadequate

We rated well-led as inadequate because:

- Some staff were not aware of the plans for the county wide management of emergency surgery in inpatient services. However, the trust told us this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service.
- There was a countywide strategy for surgical services but not all staff were aware of it.
- The governance framework did not have oversight of all risks however it had improved since our previous inspection.
- There was lack of updated action plans for the ongoing risks on the risk register.
- Senior leaders did not have oversight of all risks, for example the lack of compliance to trust policy for venous thromboembolism screening.
- Staff told us there was disengagement between consultants, department managers and the divisional leaders.
- Staff felt pressured into accepting patients onto the wards when they were already full.

However:

- There were regular staff meetings at all levels and information was shared with staff.
- Local department leadership was strong, matrons, ward and theatre managers were visible and supportive to staff.

Leadership of service

- There was a divisional director, divisional manager and director of nursing who lead the surgical services division. We met some of the management team; they were dedicated to their roles and responsibilities. Various grades of staff told us there was disengagement between the department managers, consultants and divisional managers and trust board. Some clinical staff did not feel listened to and were unaware of the plans for the surgical division, especially in relation to bed capacity and county wide emergency services.
- Each ward and theatres had a manager who provided day to day leadership to staff members. There were

matrons for the different surgical specialities who staff found to be responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.

- We saw strong leadership, commitment and support from the ward managers and theatre managers. The local management teams were responsive, accessible and available to support staff during challenging situations such as managing deteriorating patients and to support an upset family.
- Junior surgical doctors reported consultant surgeons to be supportive. Junior doctors told us they felt well supervised by consultants.
- Most staff were aware of the chief executive officer (CEO) and the chief nurse but had not seen them visit their area. Some ward managers had attended a breakfast meeting with the chief nurse, which they found useful, as hospital updates and urgent messages were shared.

Vision and strategy for this service

- The trust's values were Patients, Respect, Improve, Dependable, and Empowered (PRIDE); most staff were familiar with these. Staff had an understanding of the values and were able to explain briefly what they meant.
- During the last inspection, plans for a countywide management of emergency surgery were not implemented. During this inspection, we found these had still not been fully implemented and some staff told us they were confused about the countywide plans such as which surgical services each hospital would provide. However, this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service which had not been achieved due to a lack of capacity at Worcestershire Royal Hospital. The trust told us they had pathways in place to help mitigate any risks.
- Some senior staff raised concerns with lack of engagement, planning and decision making with the surgical leaders and trust board.
- There was a countywide strategy for surgical services but not all staff were aware of it. We saw a surgical division control plan for 2016/17, which had identified risk areas within the surgical division and priorities. This included vacancies, treatment times, compliance with fractured neck of femur pathways and theatre utilisation. Each risk had a specific action plan, for example reviewing of job plans and the recruitment of ward administrators to assist with vacancy rates and weekly monitoring of theatre utilisation.

Governance, risk management and quality measurement

- The trust had a surgical services divisional framework for governance arrangements. During the last inspection, sharing of information had not been established at ward level. During this inspection, we found this had improved in some areas and ward managers attended divisional meetings which enabled the sharing of some information across specialities and the four hospital sites. However, the board and senior managers did not have oversight of all risks. For example, venous thromboembolism (VTE) assessments were not done in line with trust policy. This demonstrated that the trust's governance system in relation to the management of VTE risk did not operate effectively to ensure that senior leaders and the board had clear oversight of the risk of harm to patients.
- Surgical services had regular surgical divisional quality governance meetings with management representation from surgical areas including consultants, matrons, and directorate managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed.
- Each specialty within surgery held their own clinical governance meetings. We reviewed minutes of which included incidents, complaints, audits, policy update and training. These meetings were well attended by members of the multidisciplinary team and minutes were available for those that could not attend.
- Surgical ward managers and sisters had meetings with the matrons to discuss vacancies, incidents, complaints and local audits.
- The department managers held team meetings within specific wards and theatres to cascade information. We saw minutes of meetings where items such as incidents, complaints and staff training were discussed.
- The trust had completed local as well as national audits. For example, environmental audits and compliance with the safer surgery checklist was monitored in line with the trust's policy and national standards.
- The trust had systems in place to identify risks. The surgical division held its own risk register and clinical

leads we spoke with were able to identify the top risks. Risks included, staffing levels, bed capacity and managing cancelled operations. However, we did not see robust action plans in place to address the risks and some had been on the risk register for two years with little improvement, such as managing cancelled operations.

Culture within the service

- Some staff told us they felt pressured into accepting patients onto the ward when they were already full. Sometimes patients were nursed in the corridor on the ward or in a treatment room which was not designed to care for patient for long periods. However, we did not see any patients being nursed in ward corridors or treatment rooms during our inspection.
- Staff were frequently moved to other wards when there was staff shortages to help maintain patient safety. Staff sometimes did not feel comfortable working in other areas as they felt they did not have the specific skills required such as surgical nurses caring for new acute medical patient with complex needs.
- Across all disciplines staff consistently told us of their commitment to provide safe and caring services and spoke positively about the care they delivered.

Public engagement

- Trust board meetings were held in public and the venues rotated round the three main hospital sites. Minutes of the meetings were also published on the trust website.
- The trust held patient and public forums, where patient representative and staff would meet to discuss working collaboratively to enhance patient experience. We saw minutes of meetings which discussed reviewing complaints, pre-operative assessment services, patient information and discharge process.

Staff engagement

- All staff we spoke with were focused and committed to providing a high standard of safe care and were proud of the services that they provided.
- Staff surveys were undertaken. Within the surgical division, 49% of staff in the survey reported work related stress and dissatisfaction with staffing levels. Action plans in place to address the results included continued to work on addressing work related stress, improve recruitment and retention and improve the culture.

Innovation, improvement and sustainability

- Urological theatres have recently implemented new equipment and systems for destroying kidney stones to improve efficiency.
- The breast unit worked in partnership with a breast cancer charity which provided free complementary therapy for breast cancer sufferers, enhancing patient experience.

At this inspection, there had been the following improvements noted since our inspection in July 2015:

- Staff were recording incidents and receiving feedback on action plans and lessons learned.
- There was a reduction in pressure ulcers from 18 in the previous year to nine in this year.
- Our observation of practice and discussion with staff confirmed that communication had improved between the managers and staff.
- Documentation of patient care had improved including the use of the Malnutrition Universal Screening Tool.
- Medical outliers were reviewed daily and ward staff could access medical staff for advice when required.
- There were daily consultant ward rounds, including weekends.
- The governance framework had improved.
- There was regular staff meetings at all levels and information was shared with staff and across all four hospital sites.

There were areas where there had not been any changes since our inspection in July 2015. These included:

- A lack of risk management. The risk register had captured the main surgical risks. However, there were no specific plans for most risks, such as to reduce the number of cancelled operations, review of bed capacity or review of emergency theatre utilisation.
- Vacancy rates for nursing and medical staff remained high.
- There was no clear strategy for a county wide surgical service. County wide management of emergency surgery had not been fully implemented.
- There was still no access to 24 hour interventional radiology.

Surgery

- There were mixed performance from the hips fracture database audit, we saw one patient that waited four days for surgery.
- There was mixed performance for national emergency laparotomy audit.
- The admitted referral to treatment time was consistently below the England average of 80%, in all specialities at 68%, apart from ophthalmology which was 86%.
- Cancellations of operations remained high at 14% compared to the national average of 6%.
- There were still high levels of unplanned medical admissions onto the surgical wards, resulting in some cancelled operations.
- There was insufficient capacity in emergency theatres.
- Patient were not always offered a choice about where they were discharged to for continuing care.
- Staff told us there was disengagement between consultants, department managers and the divisional leaders.
- Staff felt pressured into accepting patients onto the wards when they were already full, when privacy and dignity could not always be maintained.

Critical care

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

Information about the service

Critical care services at the Worcestershire Royal Hospital consist of a critical care unit and two specialist high dependency units. Critical care is managed by the theatres, anaesthetics and critical care division and operated separately to the high dependency units, which are managed by the surgical division.

Critical care unit (CCU)

The service manages the critical care units at the Worcestershire Royal Hospital and the Alexandra Hospital in Redditch to provide a countywide approach to critical care. The countywide approach enables the service to manage the flow of patients across both hospitals, flexing the service delivery to meet the demand.

The service has a clinical consultant lead, a matron and general manager who report to the theatres, anaesthetics and critical care divisional leads.

The Worcestershire Royal Hospital critical care unit was reconfigured in 2000 and is located adjacent to the emergency department. The unit can care for up to 15 patients requiring intensive care (level three) or high dependency care (level two). Level three refers to patients requiring multiple organ or advanced support such as respiratory ventilation, whereas level two care refers to patients requiring support for a single organ such as renal replacement therapy. Patients are admitted to the unit for treatment and care following complex operations or following a clinical emergency.

In addition to the critical care beds, the service managed the critical care outreach team, who provided support across the hospital for the management and monitoring of acutely unwell patients. The service was operational between 7.30am and 8pm daily.

The service admitted 643 patients from September 2015 to August 2016.

High dependency units (HDUs)

The four-bedded surgical high dependency unit is situated on the surgical day case unit and admitted patients who were cared for by the surgical team. From November 2015 to November 2016, the high dependency units admitted 958 patients.

The four-bedded vascular high dependency unit was located on Severn ward and accepted pre and post-operative vascular patients. In 2015, the vascular HDU cared for approximately 400 adult patients. The hospital also provided advanced care for general surgery patients in a four-bed high dependency unit on Beech ward.

We last inspected the service in July 2015 and found to be good across all areas. We completed an announced inspection on the 22 to 25 November 2016. We visited all clinical areas, and spoke with 21 members of staff including doctors, nurses, allied health professionals and administration staff. We spoke with 4 patients and reviewed 14 patient records and notes.

General critical care services provided by this trust were located on two hospital sites, the other being Alexandra Hospital, Redditch.Services at Alexandra Hospital are reported on in a separate report.However, general critical

Critical care

care services on both hospital sites (excluding the HDUs in Worcestershire Royal Hospital) were run by one critical care management team.As such, they were regarded within and reported upon by the trust as one service, with many of the staff working at both sites.For this reason it is inevitable there is some duplication contained in the two reports.

Summary of findings

Overall we rated the service as requires improvement because:

- We found that clinical incidents were not always categorised accurately or reported externally. We saw evidence that staff remained confused as to what constituted a near miss incident and reported incidents as a near miss when patients were placed at risk.
- Outside of critical care, staff felt pressurised and unsupported. Nursing staff felt that patient care was not a priority to the trust.
- The executive team were not visible across the organisation and staff felt that the lack of a permanent executive affected progress.
- Nursing records within the high dependency units were not always contemporaneous, with data entries being completed at the end of clinical shifts and not when events occurred.
- The clinical environment for the critical care and high dependency units did not meet all the recommendations set out in the Health Building Note 04-02 Critical care units' standards. This included limited washing and toileting facilities for mobile patients on the critical care and high dependency units.
- Staff did not always adhere to infection control and prevention practices.
- Consultants assisted paediatricians in the management of children admitted as an emergency until transfer to a children's specialist hospital was arranged.
- Patients on the high dependency units who were categorised as level two due to arterial line being in situ were not provided with additional screens or privacy when placed in beds opposite a member of the opposite sex.
- We saw that venous thromboembolism assessments were not always completed in line with recommendations, with the repeat assessment after 24 hours of admission missing.
- Mandatory training compliance did not always meet the trust target. High dependency staff had not completed critical care handbooks at the time of inspection, although these were in progress.

Critical care

- Medical consultants were not always allocated to the care of patients following discharge from critical care, which affected patient follow up after discharge.
- There was a limited follow up service for patients discharged from critical care with no provision of a formal medical lead clinic.

However:

- Critical care staff completed a daily safety brief where they discussed any incidents or complaints and identified learning. Learning was also shared across the service at team meetings.
- Appropriate staff regularly reviewed patients. Medical teams reviewed patients a minimum of twice daily. The critical care outreach service assisted with the monitoring and treatment planning of sick patients across the trust, providing local support for teaching and monitoring of compliance in trust wide deteriorating patient audits.
- Critical care were able to ensure safety across the county wide service by transferring skilled staff to assist with the management of patient care according to need.
- The service had implemented a weekly multidisciplinary team meeting to review patients' rehabilitation needs.
- Critical care used evidence based patient pathways, policies and protocols to provide care.
- Trust data published by the Intensive Care National Audit and Research Centre detailed that the service performed in line with similar sized organisations and as expected.
- The service provided a seven-day service with access to specialists such a dietetics and pain specialists for additional treatments or advice. Specialist were involved with the planning of treatments and participated in multidisciplinary team meetings.
- The service had a robust training programme for staff that included the use of a competency handbook, local training support from the practice development nurses and scenario based training.
- Patients and their relatives were treated in a compassionate, respectful manner. Staff provided privacy for relatives and patients. Patients and their relatives were supported during their stay within critical care with staff offering opportunities to discuss care and treatment.
- There were additional facilities within the critical care unit, which enabled patient's relatives or loved ones to stay on site. There were also facilities for those requiring additional support for aspects such as learning disabilities, translation services.
- Staff and relatives used patient diaries to record events. These helped patients understand what had happened whilst they were sedated.
- There were systems in place to address formal and non-formal complaints. The most relevant persons completed investigations and responses and learning shared amongst the team though open discussion and team meetings.
- Critical care had a vision of the service, which reflected the trust core values.
- The service had a robust governance structure and cascaded service performance data to the trust board and to staff on the units.
- Local leaders were reported as being supportive, accessible and approachable.

Critical care

Are critical care services safe?

Requires improvement

We rated safe as requires improvement because:

- Clinical incidents were not always categorised accurately and reported externally.
- Staff remained unclear to the definition of near miss incidents and incorrectly reported incidents as a near miss when an incident actually occurred.
- Patients' records in the high dependency units were not always contemporaneous.
- Staff did not always adhere to safe infection prevention and control measures.
- The units did not meet all the recommended building guidance. For example the service did not a ceiling mounted hoist, enclosed storage facilities for small quantity items or wall mounted dialysis water.
- Mandatory training compliance did not always meet the trust target.

However:

- Critical care staff completed daily safety briefings, which included discussions of current issues and feedback from investigations and mortality meetings.
- Critical care safety thermometer data showed no patient harms from September 2015 to September 2016.
- Critical care had implemented the same devices across all locations to promote safety when staff temporarily relocated to another site.
- The service provided critical care outreach services between 7.30am and 8pm, with support for deteriorating patients overnight completed by the hospital and night team.
- The critical care outreach service completed a trust wide audit in the completion of national early warning scores and the appropriate escalation for deteriorating patients.
- Staffing was flexed across the critical care units at the Worcestershire Royal Hospital and the Alexandra Hospital to ensure patient safety. This ensured that there were sufficient staffing levels in both critical care units to manage the safe care and treatment of patients.
- Critical care had implemented a weekly multidisciplinary team meeting focused specifically on the rehabilitation of patients.
- All patients were reviewed a minimum of twice daily by a consultant.

Incidents

- The safety performance data showed that staff reported incidents; there were low numbers of unit-acquired infections and errors leading to patient harm. However, we found that there was some confusion as to the classification of incidents and the reporting of incidents externally.
- During our previous inspection, we identified that the service was categorising incidents incorrectly with incidents being classed as "near misses" when the reports showed that the incidents actually occurred. Service data showed that 20 near misses had been reported from September 2015 to August 2016, 16 of which detailed incidents that had occurred and not "near misses". Similarly, to the previous inspection, incidents identified appeared wrongly classified as a "near miss" as no patient harm had occurred. For example, one patient was administered the wrong dose of antibiotics, which resulted in monitoring of bloods and a medical review. No harm was noted.
- Staff were aware of their roles and responsibilities to raise concerns, report incidents, concerns and near misses internally. However, we found that incidents were not always reported externally. For example, an incident occurred on the vascular high dependency unit whereby a patient was administered the wrong amount of controlled medication via a pump. Controlled medications are those that require extra checks and special storage arrangements because of their potential for misuse. As a result, the patient required urgent medical review and treatment to reverse the effects of the controlled medication. This incident was reported using the trust electronic reporting system and investigated locally, however was not reported as a serious incident. The NHS England: serious incident framework (2015) states that a serious incident investigation must be completed when an "unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: death of the service user or, serious harm".
- The service reported 91 incidents from October 2015 to September 2016, which included incidents relating to bed management (16), non-specified incidents (12), admissions and discharges (6), medicines (5), documentation (5), equipment (4) and staffing (3). The

remaining incidents reported related to topics such as patient falls (2), clinical infection (2) and information security (1). During the same period, no incidents were categorised as a serious incident. There were three incidents that resulted in moderate harm, which included death of a patient whilst waiting for a bed within another specialist provider, electrical burn from equipment and a side room not cleaned appropriately. A further 27 incidents resulted in minor harm such as accidental removal of lines and pressure tissue damage. The remaining 61 reported incidents resulted in no harm. We saw that incidents were reported across the team to highlight learning and understanding.

- Local investigations of incidents were reviewed during inspection and found to be detailed and thorough. We saw incident reports completed by the ward sister on surgical high dependency shared with all staff.
- Service data confirmed that there had been no never events within critical care from October 2015 to September 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic barriers are available at a national level, and should have been implemented by all healthcare providers.
- The critical care team were observed discussing incidents and learning at daily briefing meetings. The safety briefing included alerts from the national patient safety agency (NPSA) and any incomplete actions. The multidisciplinary team attended the briefing, and staff were encouraged to discuss any concerns or investigation outcomes.
- Patient records on critical care contained detailed data entries relating to incidents and discussions with patients and their family.
- The service completed two safety meetings per month. The critical care governance forum reviewed issues relating to patient safety, patient safety alerts, mortality and morbidity and changes to guidelines. Meeting minutes were detailed with evidence of discussion and actions. Minutes were shared across the team to ensure staff were aware of issues discussed.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- Nursing staff and medical staff were fully aware of the duty of candour and described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. We did not see any examples where duty of candour had been implemented in practice.

Safety thermometer

- All services completed the monthly point prevalent safety thermometer audit. This is a national audit, which captures patient harms on one specific day each month. The audit captures harms associated with new pressure ulcers; patient falls with harm, urinary infections and venous thromboembolism (Deep vein thrombosis). Service data confirmed that there had been no patient harms from September 2015 to September 2016. This included no pressure ulcers, no falls with harm and no catheter associated urinary infections.
- In line with best practice, we saw that safety thermometer data was displayed for staff to view.

Cleanliness, infection control and hygiene

- The service had systems in place to prevent and protect people from a healthcare associated infection. This included cleaning schedules, auditing and monitoring.
- We saw that the services audited compliance against cleaning schedules and trust policy for areas such as uniform, hand hygiene and surgical site infections. Data was displayed for staff to review. Data collected confirmed that critical care achieved 100% compliance in all infection control audits from April 2015 to October 2016.
- We saw that staff generally used appropriate personal protective equipment for all patient centred activity and contact. The exception of this was the vascular high dependency unit where nursing staff demonstrated several incidents where practice was not in line with safe infection control practice. For example, we observed

one nurse using contaminated gloves to silence an alarming pump, and another nurse answered the ward door wearing gloves, a protective apron and carrying a bedpan.

- We saw that all nursing staff washed their hands before, after patient contact, and before completing any other tasks.
- Nursing staff were observed wearing colour coded aprons for activities in line with trust policy. This included green aprons for issuing food and white aprons for patient contact.
- Patients with suspected communicable illnesses were isolated in side rooms within the critical care unit. Side rooms had laminar flow capabilities, which enabled appropriate isolation.
- Trust data confirmed that there had been no MRSA bacteraemia or colonisations attributed to the service since May 2015. There was no data relating to the number of MRSA bacteraemia or colonisations attributed specifically to the high dependency units, however trust wide hospital occurrences were low.
- Patient admitted to the service were screened for MRSA on admission and rescreened each Monday to monitor. We saw that patient's records confirmed this.

Environment and equipment

- The critical care unit was on the second floor of the main hospital site, situated next to the emergency department and theatres. There was sufficient space within the unit to provide care for up to 13 patients and an additional two side rooms. Each bed space had an individual sink, ceiling mounted pendant for equipment, nursing desk and equipment trolley. There was sufficient room at each bed space for additional equipment and staff to attend patient's needs. The Health Building Note (HBN) 04-02 Critical care units, sets out the requirements for location and environmental features of critical care units and can be used to assess the suitability of services environments. The clinical lead for critical care completed an HBN 04-02 audit in February 2016, which identified that the service was compliant with 35 out of 65 reference points.
- The clinical leads for critical care completed an HBN 04-02 audit across all areas. The critical care unit was not compliant with 11 out of 65 reference points including no ceiling mounted hoist, no enclosed storage facilities for small quantity items, no television facilities and no wall mounted dialysis water. The service was partially compliant with a further 12 reference points including access to equipment such as electrocardiogram (ECG – for tracing activity of the heart), blood warmers for transfusions, endoscopies and vacuum dressings. The service did not have the recommended minimum safe level of infusion pumps (minimum requirement three pumps per bed space) or syringe pumps (minimum requirement four per bed space) for each bed space. If all beds were in use, the unit would require a minimum of 45 infusion pumps (there were 25 reported) and 60 syringe pumps (there were 51 reported). The number of devices had increased since our last inspection. There was no evidence to suggest that the number of available devices affected patient care and treatment. We did not see any evidence that the service was planning to address any noncompliance during inspection.
- Both surgical and vascular high dependency units were four-bedded bays converted from the main clinical ward. Each area had designated areas for the storage and preparation of medications, shelving for equipment and a small nurse station. Neither unit met the Department of Health building guidelines for modern critical care units. Bed spaces were small, did not have ceiling mounted pendants for equipment and isolation for infection was not possible. The service audit confirmed that the surgical high dependency unit (SHDU) was not compliant in15 out of 65 reference points including, one sink for four patients, no ceiling mounted pendants, insufficient sockets and distance from the emergency department. The unit was partially compliant with17 further reference points including the number of oxygen outlets, access to equipment such as pumps, ultrasound equipment, ECG machine and non-invasive ventilation. The vascular high dependency unit was non-compliant in 17 similar reference points to the SHDU, and partially compliant in a further ten. We did not see any evidence that any of the compliance issues affected patient care. To address the noncompliance and provide a streamlined approach to high dependency care the trust was planning a new high dependency unit on site, and were currently completing a business case.
- The patient observation chart required checks of equipment and the environment to be recorded each

morning, afternoon and at night. For example, oxygen, suction, the ventilator, monitors, pumps, the bed and patient bed space were checked for different safety elements.

- All equipment was stored locally in critical care to enable access when required. We were told that all equipment was serviced annually to ensure that it was suitable for use. This included the servicing of specialist equipment by the manufacturer however; we did not see any stickers on equipment that confirmed this. We saw a maintenance schedule, which detailed the date of service, due date for next service and date for replacement. All equipment was noted to be serviced appropriately.
- Each staff member received training in equipment used across the service and we saw competencies confirming individuals training. To promote safety, the service had introduced the same equipment across all sites. This meant that when staff were asked to work at another site, they would be familiar with the equipment in use. The exception to this was the monitors, which were manufactured by different companies, but worked similarly. A business case had been prepared requesting the provision of the same monitors on both sites.
- Nursing staff told us, that equipment was occasionally shared between the Worcestershire Royal and Alexandra Hospitals critical care units. During periods of high activity on one site, if necessary, equipment was transferred between sites using secure transport.
- The service had systems in place to manage waste. All staff used appropriate clinical and general waste bags that were segregated and removed at regular intervals by the domestic team. We saw that single use items were disposed of appropriately in either clinical waste or sharps bins.
- All sharps bins were assembled and labelled correctly with the date, time and name of assembler. Sharps bins were secure, elevated on stands, and found to be below the recommended fill level.
- Equipment on the resuscitation trolley was not secure, although due to its location and nature of the unit, unauthorised access would be difficult. Medication and intravenous fluids were accessible in sealed paper or bags. The resuscitation council suggests that medication can be stored in this manner but should be tamper evident. We saw that the critical care staff were trialling tamperproof stickers, however we saw that these could easily be removed and placed back in situ after removing items from the trolley.
- All clinical areas had completed daily checks of emergency equipment. The exception to this was the paediatric emergency trolley on critical care, which was checked monthly. We requested the policy to confirm this practice, but this was not provided by the trust.
- The service attended the medical devices meetings, which were held every two months. We saw minutes from the July 2016 meeting, which included details of equipment purchases, training needs, appliance testing and including details of sharing information in the patient safety bulletin and intranet.
- The service maintained an equipment replacement log, which was observed during inspection. The majority of equipment was due to be replaced after 2018 however; we saw that there were four patient warming devices that were due to be replaced in 2014. These were low risk items that were reported to be used infrequently and were serviced in 2015. There were no reports of any impact on patient care.

Medicines

- The service had systems in place for ensuring the safe management, prescribing and administration of medications.
- We reviewed 14 medication prescription charts and found them to be legible. All charts were appropriately labelled and detailed patients consultant, weight and allergies. We saw that all medications had been given as directed or appropriate records were completed to detail reasons for omissions.
- On critical care, we saw that all medication was secure in locked cupboards within the treatment room. Intravenous fluids were stored on raised shelving or cupboards. Since our last inspection, critical care had commenced the daily recording of the ambient treatment room temperature. Three months of data showed actions had been taken to address the heat on occasion that the temperature was elevated. This included increasing the ventilation and using fans.
- Critical care had two medication fridges, one for routine medications and another for emergency medication. Both were located in the treatment room. The emergency fridge was not locked. Nursing staff reported that this was to prevent possible delays in accessing

emergency medication whilst locating keys. Fridge temperatures were checked and recorded daily. Three months data showed that the temperature had been consistently within recommendations. The service had a poster on each fridge, which detailed actions to be taken if the recorded temperatures exceeded the recommended levels.

- On the vascular high dependency unit, the emergency medication fridge was located in a locked cupboard situated in the main ward corridor opposite the entrance to the unit. Nursing staff reported that this was arranged to ensure that emergency drugs were accessible at all times.
- The high dependency units had small medication cupboards and a controlled medication cupboard within the four-bedded bays. All cupboards were locked during inspection. We saw that controlled medications were managed in line with legislation. Staff recorded the use of all controlled medications administered, any destruction of stock and completed regular checks. Stock levels were completed locally twice daily within critical care, and daily within the high dependency units. Pharmacy staff completed stock checks every three months in line with trust policy. We saw that patient's medication charts correlated to the data entries within the controlled medication record.
- There was a process in place to monitor the use of antibiotics across all clinical areas. This included regular reviews of antibiotic treatment regimens and discussions with microbiology regarding possible treatments.
- Trust data showed that the pharmacist attended the unit for approximately 45% of their working week. The pharmacist would complete medication reviews for all patients and offer advice on medication management and prescribing.

Records

- Patient's records were managed in a standardised format across the critical care unit. Patients care and treatment was recorded on a large daily patient proforma, which detailed assessments of clinical condition, blood results, patient agitation scores, and care plans. The nurse completed each proforma for the patient. We saw that nurses caring for patients updated these records regularly with details of activities and treatments. All records were legible. Critical care medical notes were recorded on yellow paper to enable identification and held separately in a patient file. Medical notes were stored at the patient bed space in a drawer to enable access in an emergency. Although the notes were not locked, access to the unit was by request, and patients supervised at all times.
- Both high dependency units stored patient observations, and medication charts at the end of the patient bed. The patient proforma was less detailed than those used within critical care, but also contained patient assessments and observations. A file containing medical notes and nursing risk assessments and care plans was held at the nurses' station. These were not secure, and could be accessed by unauthorised persons, although the risks associated with this are low due to the nature of the units. All persons attending the units would be observed throughout their visit, as a nurse was always present.
- The high dependency units nursing notes had details of activities and treatments, but consisted of one entry usually at the end of the clinical shift. Medical notes contained details of surgical team and critical care consultant reviews.
- Patient records confirmed details of clinical assessments and treatment plans devised during each review. Data entries were in chronological order were signed, dated, and detailed contact numbers. We saw that medical data entries did not always included general medical council identification numbers.
- All patients' records demonstrated personalised care and multidisciplinary team input. There were detailed entries relating to personalised treatment plans and evidence of evaluation from all specialities.
- We saw that patient's notes detailed decision making regarding admission to the critical care unit and ceilings of treatments. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines: acutely ill adults in hospital: recognition and response to acute illness in adults in hospital. There was also evidence that the decisions were discussed with family members as close to the time of decision as possible.
- Patient's records on the high dependency units did not show evidence of decision making for admission to the units. However, nursing staff reported that beds would often be booked in advance for specific procedures at the consultant's request. Medical notes confirmed that patients were to be transferred to the high dependency unit following the clinical procedure.

- We saw that screen savers were in use across all clinical areas to prevent unauthorised persons from seeing personal identifiable information. The only exception to this was within the vascular high dependency unit, where the computer screen detailed all inpatients within the main ward. The screen was not visible to patients or visitors.

Safeguarding

- The service had access to the trust policies and procedures for the management and escalation of suspected safeguarding concerns. This included a local lead contact number. Safeguarding posters were also displayed across the site detailing contact numbers for relevant team members.
- With the exception of one consultant, staff within the service did not complete safeguarding children level 3 training which was not in line with the Royal College of Paediatric and Child Health guidelines or the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for the assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.
- The trust provided staff with mandatory online safe child and safe adult level two training. This is the recommended level of training for staff that have contact with patients and is designed to enable staff to identify anyone who is vulnerable and details on how to escalate concerns. Safe child training had been completed by 89% for nursing staff, and safe adult training completed by 100% of nursing staff.
- Staff we spoke with were able to describe incidents that would prompt them to consider a referral to the safeguarding team. They were able to demonstrate how to access the trust intranet and report an issue to protect the safety of a vulnerable patient.
- Critical care did not admit children under the age of 16 to the unit and all cases were transferred to a specialist hospital. In emergencies, the consultants would assist with the management of a child to ensure safety whilst waiting for collection by the specialist team.
- Nursing staff told us that patients between 16 and 18 years could be admitted to critical care for treatment. These were usually planned admissions following discussion with the patient and an assessment of their suitability. Medical staff confirmed that patients who were adult size could be facilitated in a side room on the unit, if they wished. This was reported to be infrequent. Trust data showed that four patients aged between 16 and 18 years were admitted to the unit from November 2015 to November 2016.
- The service did not provide female genital mutilation (FGM) training. Staff we spoke with were aware of FGM, but this was through either previous training from other trusts or because of individual professional development.
- We saw staff using passwords to identify friends and family members for information and visiting.

Mandatory training

- The service monitored mandatory training compliance across both the Alexandra and Worcestershire Royal Hospitals. This was in response to the service providing a countywide service.
- The trust had nine core mandatory training topics, which included clinical and non-clinical skills. Training included topics such as basic life support, infection control and prevention, manual handling and health and safety. Trust targets for compliance were 90%.
- Critical care achieved compliance with all training with the exception of information governance (87%) and health and safety (75%). We were told during inspection that staff were aware of the needs to complete their mandatory training and attendance had been planned.
- Training compliance for the high dependency units was not made available during inspection.
- Training records were updated every two weeks. Staff were reminded of the need to renew training by email.
- All staff completed an induction-training programme when they commenced post.

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to patient risk through regular review. Ward rounds were conducted twice daily (in the morning and evening) and led by the consultants on duty. There was input to the ward rounds from unit-based staff including at all times the doctors and the nurses caring for the patient. The senior nurse (sister or charge nurse) would attend the whole ward round.
- Patients were closely monitored to enable a response to any deterioration. Where possible nurses would be placed with the same patient throughout the patient's stay ensure consistency.

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- Patients were monitored for different risk indicators. Each ventilated patient was, for example, monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Equipment was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.
- Services completed comprehensive risk assessments based on national guidance for all patients. This included venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- We saw that the staff completed the initial VTE assessment, however, did not see any evidence to support repeated assessments after 24 hours of admission. This is not in line with NICE QS3 guidance.
- Throughout the service, we saw that VTE assessments were recorded on admission to hospital. A tick on patient's drug charts and records within the clinical assessment documentation evidenced this. We did not see any evidence to support repeated assessments after 24 hours of admission, which is not in line with NICE QS3 guidance.
- The service provided a consultant intensivist to manage patients on the high dependency units and to manage any referrals into critical care. Referral was usually following an assessment by the critical care outreach team, the hospital at night team or following an emergency. Referrals were always consultant to consultant.
- The critical care outreach team worked 7.30am to 8pm daily. The team would track discharges from critical care to the high dependency units or wards to ensure that they were stable upon discharge. In addition to discharges, the team would see any patient referred to the service and offered advice on treatment.
- At night, the critical care outreach team would hand over the service to the hospital at night team. This team received handover from the outreach team and continued to monitor patients referred to the service. The service did not use an electronic patient handover process. We were told that staff had trialled electronic handovers; however, staff did not like the process and resorted back to verbal handover with written notes.
- Since the last inspection, the trust had introduced the National Early Warning Score (NEWS) for monitoring patients in line with NICE guidance CG50. This system enabled the recognition of deteriorating patients through point allocation to clinical observations such as blood pressure and pulse. The NEWS charts outlined actions to be taken for abnormal readings and escalation processes. The service completed a trust wide NEWS audit, which were reported on the unit dashboard, reviewed by the service leads, and escalated to trust board. Ward sisters were required to complete action plans to address any non-compliance and the audit repeated.
- We also saw that the acute medical team completed an audit of care of the acutely ill patient, which was based on the NICE guidelines. The audit looked at 39 patient across the trust and identified that 33% of the patients had observations recorded on admission or at initial assessment, 33% patients had clear monitoring plans, 100% patients were monitored using a track and trigger system, 100% patients were monitored a minimum of 12 hourly and 82% patients had observations increased in response to abnormal readings. The critical care outreach team were in the process of completing additional trust wide training for staff to help improve compliance.
- The critical care outreach team completed an audit of NEWS for unplanned admissions to critical care. Findings showed that ward staff were completing patient observations as specified however, were not recording actions taken for escalation. The outreach lead told us that patient admissions to critical care were reviewed and confirmed that patients with an elevated NEWS had been appropriately admitted to the unit despite the lack of documentation. We saw one incident report relating to the death of a patient following the incorrect monitoring of clinical observations.
- We saw that deteriorating patients across the trust were discussed with the consultants on call for critical care to identify the best location for that patient. Patients were transferred to the high dependency units when they were stable and no longer required critical care.
- We saw patients transferred into and out of the critical care and high dependency units. The transfers were managed as smoothly and quickly as possible to prevent compromising patient clinical condition. Critical care staff reported that on occasion, if there was a delay in a patient discharge and a new patient required an

urgent admission, the service would accept the admission into an additional bed space prior to the patient discharge. This enabled patients to be cared to in the most appropriate area, by appropriate staff.

- The trust had implemented a sepsis bundle in September 2016 and sepsis awareness was included in all training completed by the outreach team. Patients with a suspected sepsis were treated in line with national guidance. We saw that patients admitted with suspected sepsis continued their treatments, were reassessed by the consultants and monitored for effectiveness. We saw that medical notes contained evidence of a tools kit with stickers alerting staff to the sepsis bundle.
- We saw that nursing staff were quick to respond to alarms from equipment across all clinical areas.

Nursing staffing

- The matron ensured that staffing levels were in line with requirements to meet the demand of the service and national guidance for level two and three patients.
- Critical care nursing staff were flexed across the Worcestershire Royal and Alexandra Hospitals critical care units to maintain safe staffing levels. Duty rotas were highlighted to identify staff members that may need to move to the other hospital when activity was higher in one clinical area. The move would be confirmed prior to the shift to ensure that staff attended the right location for their duty. This process enabled staff to move across the service to meet the demands at any point. Nursing staff told us that they did not mind working between two sites, and transport was provided for those who did not have access to a car.
- We saw that off duty was updated regularly with any changes, and accurately reflected the number of staff on duty. The previous three months off duty was reviewed and confirmed that staffing numbers were maintained and met the Guidance for the Provision of Intensive Care Services 2015 (GPICS). Staffing was in line with the core standards throughout the inspection with level three patients (intensive care) cared for on a one to one basis, and level two patients (high dependency) had one nurse for two patients.
- The vacancy rate for critical care nurses was 11% with a 4% sickness rate, which was in line with the trust upper limit.
- Critical care unit did not use bank or agency staff, with substantive staff members choosing to either move their shifts or completed additional hours to maintain ward cover. Within the high dependency units, agency staff were occasionally used, but often would be swapped with a substantive member of staff from the base ward to ensure patient safety. We saw off duty within the vascular high dependency unit reflected the safe staffing requirements.
- Patients classified as needing intensive care (level three) were nursed by one nurse for each patient. Patients classified as requiring high dependency care (level two) were nursed by one nurse for two patients.
- Patients across the service were continuously monitored to enable any changes in clinical condition to be identified immediately. Patients identified as needing intensive care (level three) were cared for on a one nurse to one patient ratio. Those patients requiring high dependency care (level two) were cared for on a one nurse to two patient's ratio. This staffing level was in line with those recommended in the core standards for critical care GPICS 2015. We saw that off duty for the three months preceding inspection had maintained appropriate staffing levels.
- Nursing handover was completed at the beginning of each shift and given by the outgoing nurse in charge. All oncoming staff attended a handover in the staff room on the unit. This handover included the patients name, age, diagnosis and any changes in condition or planned activity. Once this was completed, nurses were allocated a patient (or patients if level 2), and then received a detailed handover about their allocated patients by the patient bedside. The nurse in charge received a detailed verbal handover for all patients following the initial shift handover. The nurse in charge maintained a written handover. We saw the handover during inspection and found that it was thorough, detailed and followed a robust system.
- Nursing handover for patients being discharged were completed using a discharge checklist, which was jointly, completed by the multi-disciplinary team. The checklist had been devised by the team to enable accurate records of clinical condition, treatments and details of follow up care. We saw this checklist in use across the trust.
- We observed and were told that the nurse in charge of the critical care unit was always supernumerary to numbers, which enabled them to coordinate activity and offer support to staff when activity increased.

Critical care

- We saw trust data confirming that the staffing levels on critical care were maintained at 100% from May to August 2016. The surgical high dependency unit had 100% nurse fill rate during days, but had reduced numbers at night with 77 to 80% fill rate from May to August 2016. The vascular high dependency unit was included in Severn ward data and showed that the unit had a qualified staff nurse fill rate from 78 to 115% for the same period. The increased figure corresponded to periods when healthcare assistants fill rate were also reduced, although were observed to be better than registered nurse fill rates. This meant that at times both high dependency units were at risk of reduced numbers of qualified nursing staff. Nursing staff on the vascular high dependency unit told us that ward staff would care for the high dependency patients and agency staff would work on the main ward.
- The critical care outreach team consisted of one band seven nurse and a small team of band six nurses. Posts were substantive and did not rotate into critical care, however, we were told that critical care staff had the opportunity to rotate out of critical care into the outreach service. We were told by the outreach lead that the team would assist with covering the critical care unit when there were staff shortages or if the unit was busy. The band 7 would attend both the Alexandra and Worcestershire Royal Hospitals during their working week whereas the band 6 nurses were rotated between sites at monthly intervals to ensure that all staff experienced the variety of care provided at each location.
- The high dependency units did not have dedicated supernumerary coordinators. Staffing was observed to consist of two registered nurses at all times. The high dependency units were part of larger surgical wards and ward sisters reported that they would assist with coordinating activity and covering breaks.
- The service had nine designated physiotherapists who attended the units to provide a variety of treatments including respiratory and passive movements. Their responsibility was also to provide respiratory therapy services across the trust.

Medical staffing

- The service had 16 designated consultant intensivists (consultants trained in advanced critical care medicine) who completed a countywide service covering the Worcestershire Royal and the Alexandra Hospitals. The level of experienced consultants in critical care was in line with the Faculty of Intensive Care Medicine (FICM) recommendations. From Monday to Friday, two consultants provided cover during the day from 8am to 6pm. One consultant was responsible for the critical care unit and the second responsible for the rest of the hospital. Junior medical staff worked alongside consultants, as part of a rotational post.
- Out of hours, a designated consultant was responsible for the service, supported by another consultant on call. On the occasions that the service was full with 15 patients, consultant cover was at the upper limit of consultant to patient ratios (1:15) FICM recommendations. Additional support was provided by on call anaesthetist who provided senior support and assistance in emergencies. The on call service was not responsible for any other services across the trust, which met the Intensive Care Society standards.
- Weekend cover was provided by one on call consultant who attended the service during the day and provided on call support out of hours. Medical staff told us that weekends were often split into Saturday and Sunday on calls. In addition to the consultant intensivists, the trust had a consultant on call for theatres and obstetrics.
- Out of hours consultants were on call and accessible within 30 minutes. The service had a senior resident core trainee (year two or above) who was also supported by the on call anaesthetic team for clinical emergencies.
- The service reported that there were two consultant vacancies at the time of inspection, however this did not affect patient care or service provision as current staff covered any gaps in service cover.
- During inspection, the consultant to patient ratio met the GPICS standards and did not exceed the range of 1:8 to 1:15. We reviewed medical staff rotas over the previous three months, which showed these levels were being consistently met.
- In line with recommendations, critical care did not have any foundation year one-trainee doctors working outside normal hours. This enabled junior doctors to complete training and supervised practice. During the week, there was a specialist registrar on duty with a foundation year two doctor or other specialist registrar. This reduced to one registrar supported by the consultants out of hours and at weekends. The doctors completed 12 hours shifts from 8am to 8pm or 8pm to 8am. The specialist registrar would also attend any

emergency calls across the hospital. Although the registrar was supported by the on call consultant and anaesthetist this was below the recommended safe staffing levels.
- We observed the medical staff handover. We saw this was well-structered, with systems in place to ensure relevant information was shared. Wards rounds were completed a minimum of twice daily, which was in line with national guidance. Handover was completed at the patient bedside, and led by the consultant. All staff were involved with the patients care was able to contribute to discussions. This included junior doctors, nurses, and allied healthcare professionals.

Major incident awareness and training

- The trust had a major incident policy, which was accessible to staff on the trust intranet.
- Staff within critical care were able to detail what actions should be taken in the event of a major incident. Action cards were available for staff to use in the event of a major incident.
- During inspection, we saw an unplanned fire alarm sound. The staff remained calm throughout, and followed local policy for the identification of the incident.

Are critical care services effective?

Good

We rated effective as good because:

- The service used evidence based treatment pathways for all admissions.
- Critical care performed as expected for six out of eight indicators within the Intensive Care National Audit and Research Centre audit.
- Critical care was supported by a pain specialist team who assisted with the management of patients within the service and tracked them on discharge.
- Critical care had a dedicated dietitian who assisted with the assessment and planning of nutritional therapy for inpatients.
- Critical care staff were completing the critical care network workbooks as competencies on commencement to post. These were completed with the support of the practice development nurses.
- Critical care had introduced routine scenario training to ensure that staff were familiar with equipment available on the unit and encourage learning.
- The service provided regular multidisciplinary team meetings that were focused and consultant lead.
- There was a robust seven-day working week system in place, with access to additional services for support to assist with the management of patients.

However:

- Staff within the high dependency units had not completed additional training in the critical care network workbook competencies, although this had been introduced and partially completed.
- Patients did not always have a nominated medical physician for follow up after discharge from critical care.

Evidence-based care and treatment

- Patients' needs were assessed on admission and their care planned in line with best practice and national guidance. Critical care admitted patients according to their needs and within timescales outlined within guidance from the Department of Health and Faculty of Intensive Care Medicine. We saw policies clearly outlined processes for elective and emergency admissions, transfer between departments and guidance on caring for patients. All policies were in date and referred to national guidance.
- Patients were treated without discrimination through the use of staff training and policies assessed and approved for equality and diversity. This included no barriers to patients on the grounds of age, disability, gender, race, pregnancy and maternity status, religion or belief and sexual orientation. There was no evidence of any discrimination on any grounds when speaking with nursing and medical staff.
- Patients within the critical care unit requiring respiratory support were ventilated using a variety of specialist equipment. This enabled patients to be treated for a variety of illnesses, including respiratory support for awake patients such as non-invasive ventilation through a mask or hood and full ventilation. We saw that ventilation was assessed regularly and changed according to patients clinical conditions. Nursing staff recorded ventilation check a minimum of hourly noting any changes when they occurred.
- The service followed the trust policy for suspected sepsis and we saw patients being treated with

antibiotics on the unit. These were recorded as being discussed with the microbiology team and reviewed regularly for effectiveness. Across the high dependency units, we saw a sticker placed in patients notes relating to the identification of sepsis and demonstrating that treatment had commenced.

- The service was not compliant with the NICE CG83 guidance that recommends that services provide designated follow-up clinics, staffed by doctors and nurse who work within critical care. The service currently offered patient follow up telephone calls after three months of discharge. These were completed by the critical care outreach team, and completed against a templated questionnaire. We did not see any completed templates during inspection. The service did not have any plans in place to develop the follow up service further at the time of inspection.
- We saw that the patient's daily record had been amended to include a delirium score, which was completed for all awake patients. This was in line with the core standards for intensive care (2013) guidance that requires all patients to be screened on admission for delirium.
- Critical care had a designated Intensive Care National Audit and Research Centre (ICNARC) data clerk, who collected performance and outcome measures for critical care patients and uploaded information into a national database. Data collected from April 2015 to March 2016 showed that the trust performed in line with England average and as expected.
- The service had commenced recording ICNARC data for high dependency patients in April 2016. Nursing staff were in the process of learning how to capture data with the support of the critical care data clerk. We requested access to the High dependency ICNARC data, however this was not provided.
- The service completed local audits in central and peripheral line insertion and management, renal dialysis catheter line insertion and management, surgical site infections, ventilator associated infections, wound care and enteral feeding. Service data showed that critical care had full compliance against all audits with 100% results monthly from April 2015 to October 2016.
- The critical care outreach team also assisted with audits across the trust, reviewing the use of the National Early Warning Score (NEWS) in patient monitoring. The audit had commenced in October 2016 when each clinical area completed a review of the current patient's observation charts to determine whether the NEWS had been correctly recorded and calculated. Results were shared with the team locally to drive understanding and compliance. We saw that ward compliance with recording the NEWS had increased from 63% to 97% from October to November 2016.
- The pain service had amended and introduced the Abbey Pain Scale for patients with delirium or dementia across the trust. This is a national tool that enables the identification of pain through patient appearance or behaviour and not reliant on vocalised complaints.
- We saw action plans relating to the development of standards across critical care. This included an action plan relating to medical and nursing staffing, operational standards and therapy and dietitian standards. The action plans were robust and based on national guidance. We saw that these were regularly reviewed and actions had completed.

Pain relief

- The pain nurse specialist team were based within the critical care unit, which enabled them to assess patients on discharge from critical care and track them to discharge. The service had no medical clinical lead, and was managed by a band 7 nurse. This was not in line with the Faculty of pain Medicines Core Standards for Pain Management (2015). Since our previous inspection, the team had implemented a number of changes, which included a trust wide administration chart for patient controlled analgesia and epidurals. The team had also developed a teaching and pain competency package, which was in use across the trust. The service was available daily from 8am to 8pm, and reviewed every patient on an epidural and in high dependency daily.
- The band 6 pain nurse specialist had completed an audit of epidural line fall out rates; we did not see the audit results but were told that the audit findings showed a significant improvement. The results had shown that the trust had a 24% fall out rate which was related to the dressings. This meant that 24% of patients with an epidural for pain control were not receiving effective pain management. The team introduced a different dressing and the audit renewed. This showed that the fall out rate had decreased to 2%.
- We saw that pain was assessed using a standard pain score and recorded regularly across the service. For high dependency areas this was recorded on the National

Early Warning Score charts, and on the individual patient record in critical care. We saw that patient received regular analgesia, as prescribed and nursing staff were quick to respond to complaints of pain.

Nutrition and hydration

- The service had appropriate policies, support and guidance to ensure that patients received specialist-feeding regimes safely.
- The service used the Malnutrition Universal Screening Tool to assess all patients for the risk of malnutrition. This was completed on admission and at regular intervals throughout the patient admission. We saw that within the high dependency units this was repeated a minimum of alternate days.
- The service had a dietitian who attended the units regularly to monitor patient progress, and assist with planning of patient care. This included the arrangements and monitoring of artificial nutrition through an intravenous infusion. The dietitian worked closely with the multidisciplinary team, which was in line with Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- We saw 14 patients' records and found that all fluid balance charts were accurately recorded with hourly data entries.
- Staff were competent at administering intravenous fluids. We saw nursing staff assessed the patient's fluid balance and hydration status, taking into account electrolyte results and discussing changes to treatments accordingly. This met the requirements of the NICE QS66 statement 2: Intravenous therapy in hospitals.
- Patients on the high dependency units and those who were awake on critical care were offered oral fluids and diets in addition to any intravenous fluids. A meal of choice could be accessed from the main ward or kitchens. Meal times were protected on the wards to ensure that patients received the support necessary to eat.

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in ICNARC the national clinical audit for adult critical care; the Case Mix Programme. Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. Critical care had a designated data clerk, who collected performance and outcome measures for critical care patients and uploaded information into the database.
- The ICNARC annual report for 2015/16 showed that the service performed as expected and slightly better than similar organisations for six out of eight indicators. This included the number of unit-acquired blood infections (1.2 in comparison to 1.6), the number of high-risk sepsis admissions (10% compared to 12.5%) and unplanned readmissions (1% compared to 1.2%). The service performed worse than similar organisations for the remaining two indicators with more non-clinical transfers (0.7% compared to 0.5%) and more delays greater than eight hours for patients deemed fit for discharge (12% compared to 6%). The critical care leads were liaising with the trust wide capacity team to arrange timely discharges from critical care; however, this was impacted by increased trust wide activity.
- The ICNARC 2014/15 annual audit reported that the risk adjusted hospital mortality ratio was 0.9. The mortality ratio for patients with a predicted risk of death less than 20% was one. Both results were in line with similar organisations.
- The service had a robust annual audit programme for evidence based national care bundles. This included monthly audits for the safe placement and maintenance of invasive lines, such as peripheral, arterial and central cannula, urinary catheter, enteral feeding care and ventilation associated pneumonia. We saw audits displayed showing 100% compliance in all topics for July to October 2016. We did not see any information regarding the readmission rates for critical care or the high dependency units.

Competent staff

- Staff within the service had the appropriate skills, qualifications and knowledge to complete their roles safely.
- Staff commencing new roles were expected to complete trust wide and local induction programme, which consisted of up to four weeks supernumerary on critical care and two weeks on the high dependency units. Staff were issued with a competency handbook, which were based on the critical care network competencies. These included theoretical learning of physiological systems,

and observed clinical assessments. The practice development nurses (PDNs) worked with all new staff to assist with learning and offer support where needed. The trust induction included all mandatory training.

- Critical care had three designated practice development nurses who worked across all clinical area to assist with the training of staff. We saw training displayed locally across the critical care unit and an audit of completed work on all sites. Training included all clinical skills such as different ventilation methods, sepsis and analysing blood results. This was in line with GPICS guidance.
- In addition to supporting competencies, the PDNs offered planned and ad hoc training sessions. We saw training agendas displayed across the unit.
- We saw that the high dependency staff had commenced the critical care network competencies as part of their development and following the introduction of ICNARC data collection on the units. We saw a number of booklets that had either been completed or commenced during our inspection. The critical care PDNs were supporting the staff to complete this and attended a variety of shifts, including nights to ensure they captured all staff.
- We spoke with the ward sister for vascular high dependency who informed us that the plans were for all substantive base ward staff to rotate into the unit to gain competence. This was planned to commence in January 2017. This meant that any staff member would be able to work within the unit as they would be trained and assessed using the critical care network competencies.
- We saw that over 57% of nursing staff had gained the post registration award in critical care nursing which was in line with the GPICS. Additional nurses were booked to attend the course in the near future.
- A consultant intensivist had implemented a weekly training programme, which was attended by the full multidisciplinary team. The sessions were scenario based and staff were expected to manage a patient's care, using the equipment available on the unit. The aim of the scenarios was to ensure that staff were familiar with equipment, its location and learn from each other's knowledge and experience. The sessions had been completed for the three weeks prior to inspection and feedback collected showed that staff enjoyed the training and welcomed the additional support and experience. The training was planned to continue with a different scenario weekly.
- The consultant team had implemented a bedside echocardiograph-training programme, to ensure competence for all staff. We did not see this in progress during our inspection, but consultants told us that they had attended sessions.
- Junior doctors reported that they were supported to learn during their placement within critical care. They reported that practice was supervised appropriately and they were involved with personal development plans to enhance their experience.
- Critical care outreach staff were trained to complete extended roles, such as requesting x-rays, male catheterisation, advanced life support, patient transfer training and arterial blood gas sampling. These skills were competency based or completed in line with training programmes.
- Critical care nursing staff had 98% compliance with annual personal development appraisals. The trust target was 85%.
- The service had regular attendance from additional support services such as a visiting critical care specialist pharmacist, physiotherapists, occupational therapists, speech and language therapists and a dietitian.

Multidisciplinary working

- We saw that all necessary staff were involved with the planning, assessing and delivery of patient care.
- We saw that the daily multidisciplinary team meeting was led by the consultant on call, and included an open discussion of patient condition and planned treatment. We saw that staff were able to discuss any concerns or ideas openly. Throughout our inspection, we saw the consultants on call communicating with all staff to achieve the best possible care for individual patients. This included discussions with high dependency staff to admit a discharge from critical care and discussions with the emergency department to admit patients for treatment. Throughout the consultant liaised with the nurse in charge for critical care to ensure that all plans were shared.
- Patients who were acutely unwell with conditions, such as sepsis, on wards across the hospital were referred to the on call consultant for urgent review. The critical care team would discuss the possibility of admission to critical care with the referring consultant and the

patient. This enabled ceilings of treatment to be identified prior to admission. We saw evidence of ceilings of treatment being recorded following discussion in medical notes.
- Consultants discussed each referral and identified ceilings of treatment where necessary. We did not see an admission criterion, and were told that patients were assessed according to their individual conditions.
- Their admitting consultant and the consultant intensivist reviewed patients within critical care daily. In addition, therapist and dietitians reviewed staff.
- We saw patients discharged from critical care being assessed on wards within 24 hours of discharge. The critical care outreach team reviewed patients being discharged from critical care prior to the move and a checklist completed as to ongoing needs and treatment plans. Upon discharge, patients were assessed the second on call consultant intensivist and the critical care outreach team. This was in line with the NICE CG83 guidance for rehabilitation after critical care. This was an improvement since the last inspection when we identified that the discharge of patients from critical care to a ward was sometimes suboptimal.
- All staff reported that they were supported by their colleagues and were able to share ideas for team or service development.
- During our last inspection, we identified that there was a poor response to the critical care unit needing information or support from the medical teams. There were difficulties in determining a physician responsible for the medical patients in critical care and no consistency in "patient ownership". During this inspection, the consultants and senior nursing lead stated that this was still an issue, and patients were often discharged home from critical care with no medical physician to follow up care. This was predominantly patients admitted for very short periods, who were fit to be discharged following initial treatment. For example, patients who had taken an overdose. This was cited on the service risk register.
- There was a multidisciplinary team approach to the weaning of patient ventilation. Weaning is the gradual decrease in ventilation support with the aim for the patient to become independent as quickly and safely as possible. We saw the team discussing weaning plans and safe parameters for the patient's condition.

Seven-day services

- Consultants on call completed twice daily ward round daily across the service. This was supported by the nursing and medical team on duty, the physiotherapist and where necessary the pain specialist nurse and outreach team. This was in line with the core standards for intensive care (2013).
- A consultant assessed patients admitted to the service within 12 hours of admission, which was in line with national guidance. Within the high dependency units, assessments were completed twice daily by the admitting surgeon and the critical care intensivist, and therefore consultant reviews were more frequent.
- The occupational therapist, dietitian and pharmacist provided additional support Monday to Friday with an on call service out of hours.
- Trust data showed that the pharmacist attended the unit more frequently than the contracted hours, spending approximately 45% of their working week on the unit.
- Doctors were available on critical care 24 hours per day. This included access to consultants. Junior doctors told us that on call consultants were accessible and supportive out of hours, answering queries and attended the unit if they required.The on-call surgical team provided out of hours medical cover to the high dependency units.
- Diagnostic services were available 24 hours per day, which enabled treatment plans to continue.

Access to information

- Staff had access to all relevant information required for the delivery of effective care and treatment during their stay within all units. The critical care unit had administration staff that could coordinate the provision and supply of patient records. Including obtaining historical notes and accessing current test results and reports.
- We saw that the service had implemented a discharge pathway, which captured key information for discharge planning. This was a template initially completed by the nurse caring for the patient and reviewed by the outreach team and therapists prior to discharge. This meant that all members of the multidisciplinary team were aware of the treatment plan and were able to track the patient to the ward. This promoted the continuity of care and was in line with NICE CG50 guidance.
- The discharge pathway was used as a standardised handover template for all discharges from critical care.

- All clinical areas had access to computers, which were password protected. Staff were able to and demonstrated accessing patients diagnostics, test results and personal information retained on the trusts electronic databases. Staff reported no issues with accessing information.
- We saw that notes of patients discharged from critical care included a discharge summary, which was shared with the receiving ward, and the patients named specialist consultant.
- The vascular high dependency unit reported that large portions of their patients are discharged home following successful surgery. On these occasions, patients were provided with a discharge letter detailed procedure undertaken, discharge medication and details of any follow up treatment or appointments.
- We did not see any transfers between high dependency units and wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff we spoke with were aware of the policy and their roles and responsibilities in the escalation of concerns.
- We saw that staff recorded patient consent to treatment where possible. When consent was not possible, staff completed treatment in line with best interests and the Mental Capacity Act 2005, for treating unconscious patients, or in an emergency. For example, patients who were sedated were unable to give consent for personal care; however, staff completed these recording details within the patient records.
- Senior nursing staff told us that they were confident in the completion of mental capacity assessments, as this skill was often required when covering the hospital wide bleep cover.
- We saw the multidisciplinary team discussing patients' mental capacity as part of the ward round. This included decisions for treatment and the arrangement of formal assessment, deprivation of liberty referrals and best interest meetings with family members. Although, we did not see any completed assessments during inspection we saw evidence that discussions regarding capacity were recorded in patient notes.
- We observed one patient who had mittens in situ, in response to them pulling at invasive lines when they were awake. Nursing staff were able to explain the rationale for use and outlined the policy requirements for their use. Decisions to use mittens were recorded in patient's notes. We requested a copy of the appropriate policy but this was not provided by the trust.
- Staff were able to describe the differences between lawful and unlawful restraint and what this meant for patients being cared for on critical care.
- We were not provided with mental capacity training compliance data.

Are critical care services caring?

Good

Overall, we found the service as good for caring because:

- Patients and their relatives were treated in a compassionate, respectful manner. Staff provided a confidential and supportive environment.
- Patients and their relatives were involved with and kept up to date with treatment plans and changes in clinical condition.
- Staff provided a good level of emotional support to families and friends on critical care.
- The service used patient diaries to inform patients of events and treatment that occurred whilst they were unconscious.
- There was a limited follow up service provided by the critical care outreach team.

Compassionate care

- We saw that all patients and their relatives were treated with dignity, respect and compassion throughout the clinical areas.
- We were unable to speak to a number of patients in critical care due to their treatments requiring them to be sedated. However, we were able to observe interactions between staff, patients and their relatives.
- We saw that staff members spent time with the patients, and interacted with them during any tasks or clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned.
- During inspection, we observed several occasions where patients were admitted to the critical care unit following a clinical emergency and one death. Throughout these

occasions, nursing staff were observed to be kind and compassionate to relative's needs. We saw that staff provided relatives with time to be alone with their loved one and offered verbal support and comfort.
- We saw that curtains were used across all clinical areas to ensure privacy during treatments and personal care. Staff were reminded to knock before entering areas when curtains were closed. Patients, who were mobile, were also able to use the relative's room washroom facilities for additional privacy.
- Patient confidentiality was maintained throughout. We saw that patient's names were not displayed and medical notes were stored in drawers. Conversations with relatives were held in quiet rooms adjoining the unit. Quiet rooms were also used for multidisciplinary team meetings to prevent conversations taking place on the main ward area and being overheard.
- We saw that staff responded quickly to any signs of patient's distress or discomfort. We saw one agitated patient whose nurse spoke gently to them, offering reassurance of their safety.
- We saw that complaints of pain were responded to appropriately. Analgesia was administered within minutes of the initial complaint, and referrals to the pain nurse specialist team made for ongoing complaints. During inspection, we saw the pain specialist nurse responded to calls for assessment within a few hours of the referral.
- We spoke with patients across all clinical areas and were told that staff were "hard working" and all patients were satisfied with the care received.

Understanding and involvement of patients and those close to them

- Relatives told us they were involved with care planning and had regular contact with consultants caring for their loved ones. We saw the consultant on call talking to relatives and planning family meetings to discuss ongoing care.
- We saw nursing staff spending time with relatives of unconscious patients, explaining changes to clinical conditions and changes to treatment following ward rounds or investigations. Nursing and medical staff introduced themselves to awake patients and relatives and offered time to answer any questions.
- We were told that the service provided interpreters for relatives who did not speak English.

Emotional support

- We saw that visitors attending the unit were greeted in a polite and friendly manner, and accompanied to the appropriate bed space and introduced to the nurse caring for their relative.
- Staff showed awareness to the emotional needs of patients and relatives. We saw curtains being drawn to provide privacy and relatives being accompanied to quiet areas for discussions or time away.
- Patient's relatives were able to complete a diary, which recorded events and treatments. Nursing staff also used these to record information, which was used when patient woke up to inform them of what had happened whilst patients were unconscious. We saw a blank copy of the diary, which gave clear instructions on how it should be used.
- A multi-faith chaplaincy service was available 24 hours, which enabled staff to access additional support for relatives and patients.

Are critical care services responsive?

Requires improvement 

Overall we found the service requires improvement for responsive because:

- Hospital wide capacity affected the ability of the service to discharge patients to wards.
- High dependency clinical areas did not provide separate sex accommodation, and did not always take actions to ensure privacy for awake patients.
- There were limited washroom facilities for mobile patients in all clinical areas.
- Nursing staff reported that mental health assessments were not routinely completed in critical care, with patients having to be admitted to inpatient areas before assessments could be completed.

However:

- The service provided countywide flexed capacity to meet clinical demands.
- Critical care provided a wide variety of facilities for patient's relatives and loved ones.
- The service had systems in place to address formal and informal complaints.

Critical care

Service planning and delivery to meet the needs of local people

- The provision of critical care beds had been reviewed by the service to ensure that beds were available where needed. This resulted in the countywide approach to service needs. Staff and equipment were moved between the units at the Worcestershire Royal and Alexandra hospitals to meet clinical demands. Patients were therefore not transferred between sites, which affected their experience and their safety.
- The trust was planning to create and build a new high dependency unit, and a business plan was awaiting approval at the time of inspection. The trust had not confirmed its plans for the high dependency units, however staff within critical care, thought that this would be an extension to the critical care unit. Staff felt that by joining the units, appropriate skills, competence and support would be available to ensure patients pathways and flow.
- The high dependency units had commenced recording Intensive Care National Audit and Research Centre (ICNARC) data in April 2016. This had resulted in the development of the staff working within the unit, with aims locally for all ward staff to be trained in high dependency care. The sister on vascular high dependency confirmed that internal rotation was planned for January 2017.
- All staff spoke openly of the plans for staff working on high dependency units rotating through the critical care unit to maintain skills and competence. We did not see any evidence to support this plan during inspection.
- All clinical areas admitted elective and emergency patients. The vascular and surgical high dependency units predominantly cared for vascular or surgical patients, however, occasionally flexed the criteria to meet the demands on the service. Staff told us this rarely included medical patients.
- Visiting times had been changed the week prior to inspection to 12 midday to 8pm. This had been in response to lengthy ward rounds in the morning. Visiting outside these hours was permitted for relatives following discussion with the nurse in charge.
- Visiting within the high dependency unit was limited to two visitors due to the limited space for large numbers of visitors. Within critical care, numbers of visitors was usually restricted to two; however, this could be flexed according to the condition of the patient.

Meeting people's individual needs

- All clinical areas within the service provided care for level two patients, with level three patients requiring a critical care bed. Staff reviewed all patients daily to ensure that they were being cared for in the most appropriate clinical area. We saw that consultants had discussions with nurses in charge of all units to arrange transfers between the areas, enabling patients to be admitted to critical care.
- Due to the nature of the units, staff were not able to provide single sex wards or areas. When patients were receiving treatment in line with level two care, staff were not required to report the mixed sex accommodation as an incident. However, when patients became level one, the mixed sex occupancy should be reported. Nursing staff told us that patients were transferred to wards as soon as possible after becoming a level one patient but there were often delays. We saw no reported incident for mixed sex breaches within critical care and two for the high dependency units from September 2015 to August 2016. This suggested that mixed sex breaches were not routinely recorded. The number of mixed sex breaches reported would also increase with the number of delayed discharges.
- Vascular high dependency staff reported that they did not report mixed sex breaches for patients if they were deemed to require level two supports. The categorisation of level two patients in this case referred to awake patients with arterial lines in situ. This meant that patients could be placed opposite a member of the opposite sex for the duration of their stay on the unit and this was not reported. On inspection, we saw that there was one female patient in a bay with two males, and one empty bed. Attempts had not been made to screen the patient from the other patients.
- We previously identified that the service did not provide specialist support for patients in critical care with psychological problems or anxieties. Although the critical care team acknowledged that, this was important. During this inspection, it was noted that there remained a deficit in psychological specialist support for both patients and their relatives.
- Staff were able to refer patients to the mental health team for assessment. However, this was reported as being problematic for patients awaiting discharge, as the mental health team would not attend an "inpatient critical care patient". Staff reported that they often

referred patients as being in the "critical care discharge lounge" which enabled an assessment to be completed prior to discharge. Patients requiring a mental health assessment, who were being transferred to another ward, received their mental health assessment at the discharge location.

- All clinical areas had poor access to bathroom facilities. Within both high dependency units, patients who required bathroom facilities would have to leave the bay and attend a bathroom on the main ward. We were told and saw, that in preference, patients were assisted to use commodes or wash bowls at their bed space. This meant that within the high dependency unit, patients' privacy and dignity was not maintained as a curtain, which did not restrict noise, segregated each bed space. Similarly, in critical care, patients had access to the relative's room, which had en-suite washing and toileting facilities. Nursing staff told us that if patients were well enough to walk to the bathroom, they would be transferred to a ward.
- We saw that entry to the critical care unit was via an intercom. Visitors were given access from the nurses station and greeted by either the nurse or ward clerk on entry to the unit. The bed space curtains within critical care had posters attached stating "do not disturb". We saw these in use throughout our visit.
- Critical care provided several relatives areas both on and off the unit. This included a small room with washroom and kitchen facilities. This ensured that relatives had privacy during their stay on the unit and enabled them to stay for a longer period. Facilities for relatives within the high dependency areas were shared with the main wards where the units were located.
- Relatives were able to access hot, cold drinks within the critical care relative rooms, and we observed staff asking visiting relatives if they would like refreshments. The high dependency units did not provide refreshment facilities, however these could be sourced on the main ward area or from the hospital café or restaurant.
- Trained and experienced staff supported patients with learning disabilities. The service had access to a trust wide learning disability liaison nurse who assisted with support and advice. To assist with promoting a calm environment the service used a "hospital passport" which contained details of the patients past medical history, their relatives, contact details, their likes and dislikes. In addition, the patient's relatives or carers were able to stay on the unit to provide additional support or comfort.
- Critical care had introduced a system to alert staff to the noise generated on the unit. The unit had a device, which lit up green for acceptable noise, amber for above acceptable noise and red for too loud. The device was situated at the back of the nurse's station and easily visible to the majority of bed spaces. Nursing staff told us this was a visual reminder that equipment and staff make a lot of noise. The service had introduced a rest period to facilitate a quiet time for patients to rest. During inspection, we noticed that lights were turned off and treatment activities were reduced as able.
- We were told that the service provided translation services, and were able to access interpreters to attend planned meetings without any difficulty. In addition, we were told that some translation was completed by multilingual staff working across the organisation.
- Critical care had a large number of information leaflets available for patients and relatives. We were told that staff could provide large print or translation to different languages if necessary.
- All areas and facilities were accessible and suitable for wheelchair users.

Access and flow

- During the last inspection, we identified that the service had a higher than average number of delayed discharge and transfers out of critical care overnight. During inspection, we identified that although the service continued to have issues with delayed discharges; the number was significantly reduced from 75% of all discharges in March 2015 to 12% of all discharges as reported in the ICNARC annual report for 2015/16.
- Patients were admitted to the service following a consultant-to-consultant referral. During inspection, we saw evidence of consultant referrals and discussions in all patients' notes. Medical notes reviewed showed that patients care was escalated following deterioration in condition. We saw that the majority of emergency admissions to critical care were reviewed by the outreach team and on call consultant prior to being accepted for treatment on the unit. Planned admissions to critical care did not include a written referral, however we saw evidence that a critical care bed was required written in the surgical notes.

Critical care

- We saw that patients requiring a critical care bed were cared for on the referring ward or clinical area by the critical care outreach team, consultant and when necessary the resuscitation team up until admission to the critical care unit. This ensured that patient's safety was maintained whilst awaiting a bed. Admission to critical care was noted to be within four hours of decision to admit and in line with the core standards for critical care (Guidance for the Provision of Intensive Care Services 2015).
- Nursing staff told us and we saw that when demand for critical care beds was high, patients were brought to the unit for safety rather than being cared for within the emergency department or theatre recovery. Nursing staff stated that patients were rarely cared for in other departments, as staff would "always pull together to ensure a patient's safety."
- A consultant reviewed all patients within 12 hours of admission to the unit. We saw that often patients were reviewed immediately on arrival to the unit.
- We saw that four planned operations were cancelled due to no critical care bed being available and 162 planned operations were cancelled due to the lack of a high dependency bed from November 2015 to November 2016.
- The service data showed that critical care had 3,831 available bed days. Point prevalent data showed that bed occupancy for critical care was below the England average for seven out of twelve months from September 2015 to August 2016. Bed occupancy was higher than the England average for the remaining five months.
- Critical care admitted 682 patients from November 2015 to November 2016. The majority of which were unplanned admissions (627) with 40 planned surgical cases and three planned medical cases.
- Trust data showed that the critical care unit discharged between six and13 patients out of hours each month from January to June 2016. The service admitted less than four patients each month for the same period.
- Service leads told us that increased activity across the trust affected the ability to discharge patients from critical care. Stating that critical care discharges were seen as "low priority" and requests for beds were "placed at the bottom of the list". Service audit data showed that the service was worse than national average for the discharge of patients delayed for more than eight hours after decision to discharge. We saw 24 incidents reported from September 2015 to August 2016 whereby discharge was delayed. The majority of incidents referred to delays in patients being discharged to wards across the trust. Although, we saw two incidents where patients were waiting more than four hours for admission to critical care, but there was no capacity. There were four incidents where patients were awaiting transfer to another specialist trust. Two of the delayed transfers to wards resulted in patients being cared for in the theatre recovery, which would affect theatres ability to manage planned and emergency operations.
- Trust data showed that of the 535 patients discharged to wards across the hospital 69 patients were discharged within four hours of the decision to discharge, 241discharged within 24 hours and 225 delayed over 24 hours. Similarly, the high dependency units reported that of the 947 discharges, 739 were discharged within four hours of decision to discharge, 157 discharged within 24 hours and 51 delayed over 24 hours.
- The high dependency units admitted 958 patients from November 2015 to November 2016. The classification of patients was not always recorded (804), with 82 recorded as unplanned admissions and 71 planned surgical admissions. We saw that one medical patient was admitted to the unit as part of their planned care.
- We saw that the surgical high dependency unit reported three delays in transfer of care from November 2015 to August 2016.
- The service performed in line with similar organisations for the transfer of non- clinical transfers. Non-clinical transfers are those transferred between units due to a lack of an available appropriate bed.
- The critical care outreach team recorded activity monthly, capturing the number of referrals, reviews and checks of devices such as lines and tracheostomies. The service recorded a total of 297 referrals, 603 reviews and 26 device checks from September to November 2016.

Learning from complaints and concerns

- Patients and relatives we spoke with told us they knew how to make a complaint or raise concerns.
- Nursing staff told us they would try to address any concerns raised locally to ensure resolution. If resolution was not possible, staff directed patients and relatives to the patient advice and liaison service (PALS).
- We were told that the service had no formal complaints from November 2015 to November 2016.

Critical care

- The service used the trust policy for managing complaints. The most relevant person would investigate any concerns, for example, complaints about nursing staff attitude were investigated by the matron, or treatment concerns investigated by the lead clinician.

Are critical care services well-led?

Requires improvement

Overall we found the service requires improvement for well-led because:

- Outside of critical care, staff felt pressurised and unsupported by senior managers and trust wide teams, such as capacity managers and discharge coordinators.
- High dependency nursing staff felt that patient care was not a priority to the trust.
- Divisional leads responsible for the high dependency unit were not addressing the pressures felt by the high dependency staff.
- Executive team members were not visible across the organisation.

However:

- Critical care had their own localised strategy, which reflected the trust wide strategy and values.
- Critical care had a robust governance structure and cascaded service performance data to the trust board and to staff on the units.
- The critical care leads were supportive, accessible and approachable.

Leadership of service

- Locally the critical care unit was managed by the consultant lead and the critical care matron, reporting into the theatres, anaesthetic and critical care division. This was in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- The service escalated and reported into the specialised clinical services division, which consisted of the sterile services, pathology, haematology, oncology, palliative care, radiology, breast screening and endoscopy bowel screening services.
- Clinical leads reported uncertainty and lack of progress in the reconfiguration of services, which related specifically to the lack of permanent executive team. Stating that there “appeared to be a lack of executive planning”.
- Staff within critical care and high dependency units were happy with the local leadership, however reported concerns with senior trust wide managers, stating that they had little understanding of the service needs and impact that plans had on staff morale.
- High dependency ward sisters were also responsible for the ward where the units were placed. Both ward sisters were line managed by surgical matrons, and reported support and regular contact with their surgical matron and the critical care matron. We saw the matrons attending the units and ward areas during our visit.
- Nursing staff reported that senior nursing team members were visible and accessible. We were told that the matrons attended clinical areas daily and chief nurse would visit occasionally. We saw the matron for critical care on the unit daily and staff responded as if this was a normal occurrence.
- We were told that the executive team were not visible across the organisation, although staff had attended the listening in action sessions arranged by the trust. Some staff reported that this was the only time they had seen the senior managers.
- Leadership of patient care and treatment was good by nursing and medical staff. Throughout our inspection, we saw that the nurse in charge was supernumerary and therefore able to coordinate activity. This was in line with the faculty of intensive care medicine standards.
- Locally we saw strong leadership, commitment and support from senior staff. Nursing and medical staff were responsive, accessible and offered support to staff during challenging or emergency situations. This was observed during inspection when a number of admissions and discharges occurred within a short period.
- Junior doctors reported that consultants were supportive and felt appropriately supervised.

Vision and strategy for this service

- Staff were aware of the trust vision and values, which were to work together for the needs of the patient and to place the patient at the centre of care.
- The service leads told us that the service had its own service values, which were supported through

education and embracing new ways of working. Staff we spoke with confirmed these values stating that the team were "working differently to provide a county wide service".
- Clinical leads were aware of the trust vision for the development of a high dependency unit. All staff we spoke with were aware of the plans and openly spoke of about their thoughts on how this may work.

Governance, risk management and quality measurement

- The service had a robust governance structure on place. Staff reviewed performance at the bi-monthly critical care directorate and monthly divisional meetings. The service used dashboards to track performance. Minutes from all meetings were made available to staff.
- We saw minutes from the critical care forum and directorate team meetings, which showed discussions of business plans, learning from incidents, the review of policies, updates on current work or action plans and feedback from the critical care network. Minutes showed good attendance.
- Critical care contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland, which was in line with the Faculty of Intensive Care Medicine core standards. This enabled the trust to show patient outcomes and other quality data benchmarked against other similar units.
- Clinical leads for all divisional specialities attended the monthly divisional meetings, which were conducted against a set agenda. The meetings used service dashboards to identify trends in quality of care and patient outcomes.
- Ward staff told us that they completed monthly team meetings, which included details of trust news, local changes, training, incidents and feedback. Staff that were unable to attend the meetings were kept informed by the meeting minutes being displayed. Meetings on the vascular high dependency unit were completed in conjunction with the main ward team meeting.
- The surgical division managed high dependency unit's performance. We saw a robust high dependency unit operational policy dated November 2016, which outlined roles and responsibilities for staff, guidance on activity and an admission criteria.
- The service had a robust risk register, which covered both the Worcestershire Royal and Alexandra Hospitals. Service leads described the three main risks as the ability to transfer patients to tertiary centres, patient discharges and the allocation of patients to medical consultants. Medical staff told that patients admitted to critical care from the emergency department were often not allocated to a medical consultant, which meant that discharging patients to wards was difficult. This also affected the follow up of patients if discharged home directly from the unit.
- Additional risks identified included the replacement of mattresses, exposure to hazardous substances, access to records and the negative impact of hospital flow on patient admission and discharges. We saw that risks were reviewed frequently and updated and amended when mitigating actions were completed.
- Nursing staff on the surgical high dependency unit reported that they received a governance newsletter monthly; however, we did not see this during inspection.

Culture within the service

- We identified during our last inspection that there was a strong cohesive culture within the service; however, during this inspection we saw that this was not the case. There was a strong supportive culture within critical care. Staff were friendly and reported that teamwork was excellent. Outside critical care, it was obvious that trust wide pressures affected staff satisfaction. We saw that high dependency staff were frustrated by the management of flow, and told us they were often pressurised into admitting or discharging patients when they did not have the capacity to care for the patients effectively. One nurse stated that following discussions with the bed manager a patient was transferred to the unit, despite explaining that they did not have the capacity to admit them, this resulted in a patient being cared for in the corridor until a bed became available. We saw that the unit had reported several incidents whereby bed pressures had resulted in patients being cared for in the ward treatment room.
- Several high dependency staff members reported being spoken to in a derogatory manner and we saw emails sent by senior nursing staff, which was abrupt and aggressive. When we spoke with staff about this, they became emotionally distressed, stating that they felt unsupported and "unable to provide the level of care patients deserve".
- All staff reported that they were committed to providing safe effective patient care.

Critical care

- During our visit to critical care, we observed a period of increased activity with a number of patient transfers and procedures within a short period. We saw that staff remained calm and organised throughout, maintaining frequent communication across the team to ensure that all staff were aware of activity and plans.
- Good practice was shared across the critical care team through a local system called "Greatix". We saw that this was completed during departmental meetings to celebrate good practice and achievements.
- Staff across critical care generally reported that they felt able to provide a high standard of patient care and they enjoyed coming to work. However, outside of critical care staff were dissatisfied with their roles and the level of care they were able to provide. One nurse told us that the trust was "more concerned about bed pressures than patient care". Another nurse stated that staff were often "scared to come to work because of the way they were treated" and "a lot of staff have been off work (sick) with work related stress". When we asked if these incidents were reported, we were told, "we used to, but nothing gets done, nothing changes".

Public engagement

- Due to the nature of critical care, there was no general public involvement with how the service developed. However, patients and their families were asked to comment on care received.
- We saw a selection of thank you cards displayed on critical care from patients and relatives who had used the service. The unit reported on the number of compliments received monthly.

Staff engagement

- Critical care staff were encouraged to share their thoughts and ideas on how the service could improve. They felt included in plans and listened to.
- Staff told us that the critical care sisters and the matron were seen regularly and spent time with staff explaining rationale for changes and thanking staff for their work. Staff told us that they appreciated this support. This included the high dependency staff who felt supported by the critical care matron for the development of competencies and collection of ICNARC data.
- In contrast, staff on the high dependency units felt supported by their ward sisters, but not by the senior managers and divisional leads. Stating that managers were too busy and did not listened to them, giving examples of when concerns were escalated regarding patient transfers and not responded to.
- High dependency staff reported that they did not look forward to coming to work, because they were never sure what they would be faced with.
- Some staff told us they would check who the responsible capacity coordinator or discharge coordinators were before agreeing to work additional shifts, as this would determine the type of shift they would have.
- The service had participated in the trusts listening into action meetings and staff reported that the events had been interesting and given them the opportunity to see the executive team.

Innovation, improvement and sustainability

- The service had introduced a weekly multidisciplinary meeting to review each patient and identify ongoing treatment and rehabilitation needs. Patients were classed as requiring either pathway one, which was for patients requiring general rehabilitation through the normal service pathway. Pathway two was for patients requiring an inpatient rehabilitation period. The service also reviewed and arranged bespoke rehabilitation pathways for patients who would be discharged with a tracheostomy. The consultant anaesthetist, occupational therapist and physiotherapists attended the meeting. Each patient was discussed with actions and timescales agreed to facilitate an early discharge. This process was new, and the therapy lead was planning to commence an audit to identify effectiveness and patient outcomes.

Maternity and gynaecology

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

Information about the service

Worcestershire Royal Hospital (WRH) has 70 maternity beds. The midwifery led birth centre has four rooms and the consultant led delivery suite has 13 rooms. Obstetric theatres are situated within the delivery suite. The antenatal ward has 20 beds, the triage area has four rooms and the postnatal ward has 32 beds. There is one bereavement suite within the delivery suite which is ring fenced for maternity bereavement patients only. There are no defined gynaecology wards at the hospital. Within chestnut surgical ward there are six nominated gynaecology beds. A further four beds are ring fenced within the antenatal ward for gynaecology patients. There is also a day assessment unit, an early pregnancy assessment unit and an emergency gynaecological assessment unit at the hospital.

Between April 2015 and March 2016 there were 5,598 deliveries at the hospital. Of these births, 99% were single deliveries and 1% were multiple deliveries. The age of the delivering mother at the hospital was generally in line with England average, with 4% of deliveries being to women under the age of 20, 77% to women between 20 and 34 years of age, 16% to women aged 35 to 39 and 3% to women aged over 40.

Between April 2015 and March 2016 there were 20 medical abortions and one surgical abortion carried out at WRH. The service only carries out termination of pregnancies for medical abnormalities, not for other reasons.

During our announced inspection between 22 November and 26 November 2016 we spoke with 36 members of staff, ranging from health care assistants to the divisional director of nursing and midwifery. We also spoke with nine patients and their partners and reviewed 12 records.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- The emergency neonatal trolley in the delivery suite was not always checked daily.
- Not all equipment on the delivery suite had been safety tested.
- Not all staff had completed safeguarding children level 3 training.
- Patients had been staying overnight in the gynaecology assessment unit due to a lack of bed space.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning.
- The referral to treatment time for gynaecology patients had deteriorated and was below target.
- Nominated gynaecology beds were not ring fenced which meant these patients were often nursed on general wards.
- There was no strategy to implement the vision to expand the gynaecology service.
- We identified risks on inspection that were not on the service's risk register.

However:

- The service monitored the number of open incident reports and this was below target.
- Early warning scores were used to identify deteriorating patients.
- The service had achieved UNICEF Baby Friendly Initiative level 3.
- Staff were caring and compassionate towards patients.
- The bereavement midwife provided individualised care and support to patients and families who had experienced a pregnancy loss or stillbirth.
- Local leadership were approachable and visible across the service.

Are maternity and gynaecology services safe?

Inadequate

We rated safe as inadequate because:

- The emergency neonatal trolley on the delivery suite was not always checked daily. We found that checks on six dates in September 2016, three dates in October 2016 and one date in November 2016 were missing.
- Not all equipment on the delivery suite and Meadow birth centre had evidence of electrical safety testing. However, we escalated this immediately and the estates team attended the ward to test them.
- The service's baby security tagging system had a limited stock of tags which meant not all babies were security tagged. However, extra measures had been put in place to reduce this risk.
- Not all cardiotocograph (CTG) traces had evidence of 'fresh eye' reviews every two hours.
- Staff had poor awareness of female genital mutilation and reported not receiving any training in identification of this.
- Not all staff involved in caring for children had safeguarding children level 3.
- The service's mandatory training compliance was below target for all nine modules.
- In the antenatal clinic we saw needles and cleaning chemicals which could have been hazardous to health in unlocked rooms.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning.
- The service had a crude neonatal death rate of 1.75 per 1,000 live births, which was up to 10% higher than the UK average.
- Actual staffing levels were often lower than planned levels for registered staff.
- The agency induction proforma used in gynaecology was not robust and lacked dates and the name of the permanent staff member who inducted the agency worker.
- The service had a 40% vacancy rate for middle grade doctors, especially within gynaecology.
- Safety thermometer data was not displayed and staff had limited awareness of this.

- The gynaecology department did not have a dedicated gynaecology ward. Patients stayed overnight in the outpatient gynaecology assessment unit and were nursed in medical wards.

However:

- Staff understood their responsibilities to raise concerns and felt confident in doing so.
- The number of open electronic incident reports were below the service's target at the time of our inspection and these were being monitored daily by the clinical governance team.
- Staff adhered to infection control and prevention guidance and rooms were available if patients required source isolation.
- The environment of the Meadow birth centre was very relaxing, with each delivery room equipped with a birthing pool.
- Medications and records were stored securely.
- The service was in the process of introducing the newborn early warning trigger and track score system for babies, to identify deteriorating babies. Early warning score systems were in place for women in maternity and gynaecology.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Staff were confident in using the trust's electronic reporting system and gave examples of incidents which they had reported, for example, medication errors.
- During October 2015 and September 2016, there were no never events within maternity and gynaecology. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Between October 2015 and September 2016 there were four serious incidents in maternity and gynaecology at WRH. Three of these were incidents related to the baby only, and one of these related to the mother and baby. The bereavement team provided support where appropriate and post mortems occurred with parental consent.
- Between October 2015 and September 2016 there were 1,035 incidents. The main themes of related to treatment (96), bed management (72) and medication (68).
- During our previous inspection in July 2015, we found that the managers were not reviewing and closing incident reports in a timely fashion, and that at the time of the inspection there were over 300 open incident reports. Following this the service introduced a target of no more than 60 open incident reports. The minutes from the ward meeting in August 2016 identified that the service was not reaching this target and sent out reminders to sign statements on completion of incidents. During our inspection we saw that there were 44 open incident reports logged on the system and that this was being monitored by the clinical governance team on a daily basis.
- The service's target for investigating and closing incidents was 20 days. As of December 2016 the service met this target in 67% of incidents. Arrangements were in place for the service to write to all staff whose incidents had not been investigated and closed within the target timeframe.
- When things went wrong thorough and robust reviews or investigations were carried out. We reviewed the root cause analysis reports of the four serious incidents that had happened. The reports followed the national patient safety alert tool and clearly identified the cause of the incident.
- Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. The root cause analysis reports we reviewed had documented evidence that the women affected had been informed of the incident, and that the duty of candour had been applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation

that introduced the statutory duty of candour. For NHS bodies, the duty came into force in November 2014. Staff had a good awareness of the duty of candour and provided examples of when this had been applied.

- Lessons were learned and action was taken as a result of investigations when things went wrong. We saw examples of changes to practice as a result of incidents, for example, increased use of bladder scanners and a change in recording the length of time urine was voided following child birth.
- Lessons were shared to make sure action was taken to improve safety beyond the affected team or service. Lessons learnt were shared during staff meetings. We reviewed the minutes from the staff meetings in April, May and August 2016 and saw that missed opportunities and incident themes were identified and discussed. Attendance at the meetings varied between eight and 14 staff members. Senior staff disseminated the meeting minutes to all staff so that those who did not attend would still be kept updated. We also saw that staff rooms had posters displayed which highlighted the ward's key focuses for that month. The service also sent a weekly newsletter to all staff, which identified the lesson of the week.
- Perinatal mortality and morbidity reviews were held. However, these were not minuted and did not have attendees listed. The record of the meeting was completed as a case record. Whilst the trust told us these meetings were multidisciplinary, without a list of attendees we were unable to verify this. The trust told us there had been problems with case records being completed in a timely manner. The service provided us with two sets, from May and June 2016. We saw actions were identified in the June 2016 meeting, however, there were no timescales attached to these actions, nor a named owner. For the May 2016 meeting there were no identified actions for any of the cases discussed. This was not in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG) improving patient safety guidance. We were told that a governance administrator had recently been appointed and that learning events would be formally recorded in the future.
- The service did not hold morbidity meetings within maternity and gynaecology. The service told us that plans were in place for these to be introduced in 2017.
- The service had held a local review to see if the 10 neonatal deaths identified in the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK) report were avoidable. The review found that seven were unavoidable, and three deaths had evidence of harm due to the care the service provided. The themes identified from the three avoidable deaths were a lack of knowledge of staff in the emergency department regarding preterm labour and poor identification of women with additional needs.

Safety thermometer

- The NHS safety thermometer is a monthly audit of avoidable harms which includes perineal or abdominal trauma, post-partum haemorrhage, infection, separation from baby, psychological safety, Apgar scores (a simple assessment of how a baby is doing at birth, which helps determine whether the baby requires additional medical assistance) of less than seven at five minutes old and any admission to the neonatal unit.
- Safety thermometer data was not displayed in any ward area visited. Staff of all levels we spoke with were unaware of the safety thermometer. We were informed that the service had not collected safety thermometer data since May 2016 as a result of personnel change. However, it did collect some of this separately, including the number of post-partum haemorrhages and admissions to the neonatal unit. We were told that the divisional lead was in the process of restarting the safety thermometer data collection.
- From July 2015 to July 2016 the service had 45 postpartum haemorrhages above 2.5litres. This was slightly less than the previous year; at 47. From the beginning of the financial year; April 2016 to July 2016, there were 10 postpartum haemorrhages above 2.5litres. This was more than the national target of less than five, for that four month time period. We requested the service's action plan to reduce their rate of postpartum haemorrhages but were not provided with one.
- From April 2015 to March 2016 the service had an increased number of unexpected admissions to the neonatal intensive care unit; from 588 in April 2014 to March 2015, to 616 from April 2015 to March 2016. Unexpected admissions to the neonatal unit became a CQUIN in 2016. Although the service performed well in this target against other local units, it identified that the two main causes for avoidable admissions were babies being cold, which resulted in respiratory problems and

babies with hypoglycaemia who required glucose treatment. As a result, a concentrated dextrose gel to treat babies quickly was introduced and a neonatal nurse was put onto the transitional care unit to manage babies without the need for admission.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally maintained. All ward areas we visited were visibly clean. We reviewed the cleaning audit for the Meadow birth centre (the midwifery led unit) dated June 2016. This audit found 96% compliance for cleanliness. The two areas the centre did not meet were in relation to storing items on the floor and the sluice containing inappropriate items. We reviewed this during the inspection and found all areas compliant. We also reviewed the cleaning audit for the delivery suite. This was originally audited in May 2015 and had a red rating of 78% compliance. Issues regarding a dusty environment and dirty tables had been identified. The delivery suite was re-audited in September 2016 and all areas of concern had improved, and the suite was 100% compliant.
- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. We saw staff adhering to the 'arms bare below the elbow' requirement and personal protective equipment was available and used by staff appropriately. All rooms on the delivery suite and midwifery led unit were private, which allowed for the isolation of any patients with infections. If a patient on the antenatal ward or postnatal ward required isolation staff transferred them to one of the single bedrooms on the wards. We observed one patient with a sickness infection being isolated appropriately on the postnatal ward.
- We observed staff washing their hands between patient contact, in accordance with National Institute for Health and Care Excellence (NICE) guidance (QS61 statement 3). Hand sanitiser gel was located throughout the wards and had appropriate infection control guidance printed on it. The service audited its compliance with hand washing and being arms bare below the elbow. Between May and November 2016 the maternity service scored 98% for hand hygiene and 100% for arms bare below the elbow. Data was only provided between April and September 2016 for hand hygiene and April and May 2016 for arms bare below the elbow for the gynaecology assessment unit. This data showed that the service scored 98% and 100% respectively for hand hygiene and arms bare below the elbow.
- There were satisfactory arrangements for managing waste and clinical specimens. Sharps bins were used and suitably stored. Waste was separated appropriately.
- Screening for MRSA (an antibiotic resistant bacteria) and Clostridium difficile (a bacteria that can infect the bowel and cause diarrhoea) was done during antenatal appointments for maternity patients, if the patient had potential triggers, such as working in a healthcare environment or had been transferred from another hospital. From March to September 2016 there were no cases of MRSA or Clostridium difficile in maternity or gynaecology.
- All pregnant women were offered the influenza (flu) vaccination and pertussis (whooping cough) vaccination during their antenatal appointments after 20 weeks. We saw posters displayed in the antenatal clinic emphasising the importance of the vaccines.
- Patients who had urinary catheters in place had their risk of infection minimised by safe insertion using an aseptic technique and maintenance by qualified staff. We saw that the catheter was removed as soon as possible to reduce the risk of an infection. This was in accordance with NICE guidance (QS61 statement 4).
- We requested details of the service's puerperal (postpartum) sepsis rate and infection rate. However, the trust did not provide this data.
- We requested details of the service's readmission rates for infections in mothers and baby. However, the trust did not provide this data.
- The hospital had not undertaken a surgical site infections survey within gynaecology and therefore there was no evidence of the number of surgical site infections within this area of the service.

Environment and equipment

- The facilities and premises within maternity were well designed and maintained. The flooring in the wards was non-slip and was in good condition on all wards visited. Window restrictors were used on the wards to reduce the risk of falls from windows and the blind cords were not a ligature or strangulation risk. The obstetric theatres were located within the delivery suite, therefore, there was quick and easy access to them in cases of emergency.

Maternity and gynaecology

- The environment and facilities for gynaecology patients had been revised since our previous inspection. In order to increase the antenatal facilities the gynaecology ward at the hospital had been turned into an antenatal ward, which meant that there was no gynaecology ward at the hospital. As a result, gynaecology patients sometimes stayed overnight in the gynaecology assessment unit (GAU), which was an outpatient area. We were told that when patients stayed overnight in the GAU overlay mattresses were placed on top of the trolleys to convert the trolley into a bed. We requested the risk assessment for this on our inspection; however, staff were unable to find this. There were no shower facilities available within the GAU and the one toilet was mixed sex as it was shared with the clover clinic (respiratory outpatients). Other gynaecology patients were placed either in four ring fenced beds on the antenatal ward, on six designated beds on chestnut ward (a surgical maxillofacial ward) or could be sent to any available bed in the hospital. This meant that women could be having a miscarriage in a bay on a mixed sex ward.
- The emergency neonatal trolley on the delivery suite was not always checked daily. We found that six dates in September 2016, three dates in October 2016 and one date in November 2016 were missing checks.
- During our inspection the hospital's baby tagging security system was in the process of being changed to a different provider. Due to delays in installation, the service was still using their previous system, but had a limited stock of baby tags. Therefore, only babies with known safeguarding concerns were tagged. The service had risk assessed this and placed it on the risk register. They had mitigated the risk by informing all women that there was a lack of tags, asking them not to leave their babies unattended, posters were displayed in women's lockers and leaflets about this were also given out to women.
- All of the maternity areas were secure with buzzer entry points into the area. Triage and the Meadow birth centre also had CCTV at point of entry. The Meadow birth centre and the postnatal ward also required staff to release the doors for patients and relatives to leave the area.
- The hospital carried out environmental audits on the Meadow birth centre, the postnatal and transitional care unit, triage and the delivery suite. These audits considered the cleanliness and condition of the environment and equipment, the safety of the ward and the ambient temperature. The audits we reviewed; from May and June 2016, showed that the hospital had mixed results. The hospital scored highly in the audits for the Meadow birth centre (94%), triage (91%) and the delivery suite (93%). However, the postnatal and transitional care unit scored 81%. The ward scored particularly low for safety (50%) as not all fire doors were kept closed and not all electrical equipment testing had been done. The temperature of the ward also scored poorly; (0%), as the temperature of the ward was not appropriate for patients as it was too hot. The temperature issue had been escalated and on inspection we found the ward temperature within acceptable ranges. Neither the fire doors nor the electrical equipment testing concerns were recorded as being escalated or reported on the audit form. On inspection we checked and found that all fire doors were shut securely and all three pieces of equipment checked had been electrically tested.
- The coving on the ward was not compliant with Department of Health 2013 Health Building Note 0010 part A. The skirting from the floor did not rise far enough up to the wall and was not smooth. This meant that cracks could appear where the floor met the wall and be a source for bacteria to collect.
- In the antenatal outpatient clinic we saw that cleaning products, including cleaning sanitiser and 70% denatured ethanol spray, were kept in the dirty utility room, which had no locking mechanism. Also in the antenatal outpatient clinic we saw that the clean utility, which had no locking mechanism, stored hypodermic needles. There was a sign on the door saying staff only but no security to stop members of the public accessing the needles.
- There was enough equipment available. The service had access to cardiotocography (CTG) machines, resuscitation equipment for both adults and newborns, foetal blood analysers and foetal heart rate monitoring machines, in line with RCOG safer childbirth guidelines.
- The hospital used an electronic equipment maintenance log. This detailed the equipment number, the manufacturer, the model number, the serial number and the next planned maintenance review.
- However, we found three pieces of equipment in the Meadow birth centre (two temperature machines and one foetal monitor) and five pieces of equipment on the delivery suite (two temperature machines and three

epidural pumps) which did not have evidence of electrical safety testing. We escalated this immediately and staff contacted the hospital's estates team to ensure these were tested.

- The resuscitation trolley on the delivery suite was complete and checked daily, however, there was no algorithm for maternal resuscitation. The Resuscitaire (infant warmer and ventilator) had out of date algorithms for neonatal resuscitation, with the guidance quoting the UK Resuscitation Council 2010 guidelines, instead of the updated 2015 guidelines. This was raised with the ward manager and the service took immediate action to rectify this.

Medicines

- There were arrangements in place for managing medicines and medical gases. Medication was stored securely in locked rooms, with locks on medication cupboards. Controlled drugs were stored separately from other drugs, and topical (skin) medications were stored separately from oral medications, to avoid confusion and medication errors. In the delivery suite, antibiotics containing penicillin were stored separately from other antibiotics, to reduce the risk of administering the wrong type.
- Entonox was stored appropriately on the delivery suite. The delivery rooms had Entonox piped into the rooms and a spare cylinder was stored securely in the locked medication room.
- Medications requiring refrigeration were stored appropriately in refrigerators. The temperatures were checked and logged daily to ensure that the temperatures did not go beyond acceptable limits which could affect the efficacy (how well it worked) of the medication. On the postnatal ward the ambient room temperature was recorded as above acceptable limits (25 degrees Celsius) consistently for the previous four months, having gone up to as high as 29 degrees Celsius. Staff on the ward had raised this with estates and pharmacy on multiple occasions and had been told that if the temperature went above 30 degrees Celsius to detract one month from the expiry date, 35 degrees Celsius to detract two months and if above 40 degrees Celsius to discard all medications. We raised this as a concern on the ward, and the estates team visited and found the thermometer on the postnatal ward was not accurate and was recording a higher temperature. We were told that the manager on the postnatal ward was in the process of requesting a new thermometer.
- Pharmacy came to the wards weekly to ensure drug rotation and stock check medicine supplies. We saw evidence of their review in the controlled drug book held in the delivery suite.
- The pharmacy was open Monday to Thursday 8:30am to 5:30pm, Friday 8:30am to 5pm and Saturdays from 9am to 12:30pm. Staff accessed medications out of hours by using either the medicines locator electronic system (whereby staff could see if another ward had a medication and arrange for a transfer) or by contacting the bleep holder who had access to the emergency store.
- We reviewed four drug charts and saw that these were completed appropriately with allergies listed where necessary.

Records

- There were processes in place to ensure that patients' care records were written legibly and contemporaneously. A mixture of paper and electronic records were used. Paper records were used for antenatal notes, birth notes for births which occurred in the Meadow birth centre and postnatal notes. Records from births in the delivery suite, including cardiotocography traces, were recorded and stored electronically. The electronic record process was programmed to ensure that staff completed each section before moving on, by not allowing them to progress until each section was completed.
- Personal child health records, also known as red books, were issued in Meadow birth centre or the postnatal ward.
- Paper records were stored securely in locked record trolleys in all areas that we visited. The electronic recording system used in the delivery suite had fingerprint recognition and requested password verification at every stage of reviewing the records. An electronic trail was made automatically of every staff member who reviewed the electronic records, to ensure a clear audit trail of who had accessed or edited the record.
- We reviewed 12 records and saw that these were accurate, complete and legible. Entries in the notes were dated, timed and signed. Any retrospective entries

were made clear within the records. We saw that pregnant women had a complete record of the minimum set of antenatal test results in their hand held maternity notes, in accordance with NICE guidance (QS22 Statement 3).

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. All areas of maternity had an alert folder which had details of any woman who had booked with the hospital and had known safeguarding concerns. These women had pink envelopes placed in their records to denote to staff that this patient had safeguarding concerns. The hospital employed a safeguarding midwife who was the service's first point of call for any safeguarding concerns. The head of division told us that there were two female genital mutilation (FGM) leads.
- Staff generally understood their responsibilities and adhered to safeguarding policies and procedures. Whilst staff had a good knowledge of general safeguarding principles, we found that there was poor awareness of FGM. Midwives of all levels and a manager within the gynaecology service told us that they had not received any training in FGM identification or awareness and that they did not know of any FGM lead within the service.
- The service's FGM guidance was contained within the safeguarding children pathway. The guidance was thorough and contained both descriptions and diagrams to aid staff in identifying FGM.
- Staff on the ward were aware of any patients where there were safeguarding concerns. We observed a handover on the antenatal ward which went through the reason for the concerns, the progress with the child protection conference and the ongoing care needs. We visited the transitional care unit (TCU), where mothers and babies stayed if they required further support before discharge. Patients with concerns of ongoing history of drug or alcohol abuse were kept in the TCU for five days following birth, to observe interactions between mother and baby and check whether the baby was experiencing withdrawal symptoms.
- Under section 5 Sexual Offences Act 2003, children under the age of 13 are unable to consent to sexual activity. If a child under the age of 13 presented to the maternity or termination of pregnancy service disclosure to social services was usually required in the best interests of the child. The service confirmed that no children under the age of 13 had given birth or had a pregnancy terminated between December 2015 and December 2016. There was no policy in place to guide staff, if a child under the age of 13 presented for a termination of pregnancy.
- Staff had a general awareness of child sexual exploitation (CSE) and provided an example of a time when concerns had been raised. Staff explained they had limited dealings with these types of cases as the safeguarding midwife managed these. We did not see any leaflets available regarding CSE or details of contact details of support groups. We reviewed the CSE policy, which was part of the safeguarding children pathway. This policy directed staff to report concerns to their line manager and gave a list of possible indicators of abuse. However, it did not refer to section 5 Sexual Offences Act 2003 or the fact that a child under the age of 13 is legally unable to consent to sexual activity.
- The service had a newborn abduction policy. This detailed the steps to follow in the event of abduction or suspected abduction of a baby, as well as the chain of escalation to be followed.
- Nursing staff within maternity and gynaecology exceeded the trust's target of 90% for safeguarding adults. However, completion rates for safeguarding children level 2 (44%) and safeguarding children level 3 training (51%) did not meet the trust target.
- Medical staff within maternity and gynaecology did not meet the trust target for safeguarding adults (86%), safeguarding children level 2 (0%) or safeguarding children level 3 (19%).This did not meet the Royal College of Paediatrics and Child Health guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.
- There was an action plan in place to improve compliance with safeguarding training. The service focused on completing the training for community midwives, with a target date of 31 December 2016 for full compliance. A target date was set of 31 March 2017 for hospital based midwives. We were told that all medical staff would be booked in to complete the training by 19 December 2016. A one day 'hot day' teaching session was held in September 2016 and email reminders sent to all junior doctors in November 2016.

Maternity and gynaecology

Mandatory training

- Staff received effective mandatory training in safety systems, processes and practices. Midwifery staff within maternity and gynaecology had a compliance rate of 95%. Medical staff within maternity and gynaecology had a compliance rate of 97%. This was above the trust target of 90%.
- Maternity staff also received a three day maternity training course, every two years. This included training on CTG interpretation, obstetric and neonatal emergencies, breastfeeding and bereavement. Training was also completed, for relevant staff, when new equipment was delivered. At the time of our inspection training was being conducted for a new intravenous pump.
- Midwifery and medical staff were above the trust training target for cardiotocography (CTG) training, with compliance rates of 92% and 94% respectively.
- Simulation learning for emergency drills had also taken place. We saw that simulations had been undertaken in the Meadow birth centre, the delivery suite and postnatal ward, in June, July and October 2016 respectively. Learning points were identified for each drill; however, we saw that for all of the scenarios the team leader not being identified. This meant that although this was being identified at each drill, there had not been effective learning, as it had continued to happen at subsequent drills.

Assessing and responding to patient risk

- Risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risk assessments were completed in the community for women who had an increased body mass index, smoking and gestational diabetes, in accordance with NICE guidance (QS22). We also saw evidence that venous thromboembolism (VTE) was assessed on admission, in line with NICE guidance (QS3).
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies. The maternity service used the Worcestershire Obstetric Warning score (F) to identify deteriorating patients. This chart was colour coded, and an escalation process was in place if a patient deteriorated. However, compliance was not audited its and therefore, we were unable to obtain outcomes in relation this. We reviewed three charts and found that these were completed appropriately with scorings totalled at the bottom of the chart. None of the charts we reviewed showed a deteriorating patient and therefore, there was no need for implementation of the escalation process.
- For gynaecology patients the service had recently introduced (July 2016) the National Early Warning Score (NEWS). This is a hospital wide standardised approach to the detection of a deteriorating patient and has a clearly documented escalation response, in line with National Patient Safety Agency 2007 guidelines. We reviewed four charts and found that these were completed appropriately.
- The newborn early warning trigger and track (NEWTT), an early warning system for identifying deteriorating newborns was in the process of being introduced. The system was launched by the British Association of Perinatal Medicine in April 2015. The NEWTT chart would be used so that the temperature, pulse, respiration and blood sugar levels for newborns to were recorded.
- The service was mainly compliant with NICE guidance (CG 190) regarding the monitoring of women in labour. The service offered low risk women a choice of birthing locations, including the Meadow birth centre; the midwifery led unit at the hospital.
- Most women in established labour had 1:1 care from a named midwife. We reviewed the service's 1:1 care in labour audit (October 2016) and saw that 92% of women in established labour received 1:1 care. NICE guidance states all women in established labour should have 1:1 care. The service's performance was an improvement from 2013 when 84% of women received this level of care. A senior midwife told us that their score was partly due to the centralisation of maternity services in November 2015, which impacted on staff sickness and acuity levels. An action plan was in place to improve their level of 1:1 care with plans to increase the number of band 7 midwives and to re-audit in December 2017.
- Consultants we spoke with confirmed that they were contacted before an emergency caesarean section took place and were involved when their patient's condition gave rise for concern.
- Risk assessments were completed at booking which included social and medical assessment. The service audited its compliance within the community midwifery

team. This showed that 100% of the notes reviewed showed that the woman was risk assessed at booking, but only 33% had their risk assessment reviewed again during her pregnancy.

- The maternity triage unit saw women who were 20 weeks pregnant and above. Any women under 20 week's gestation who required assessment were seen by the GAU. Patients were prioritised based on clinical need and a target set for women to be seen within 30 minutes of arrival. Any delays of more than 30 minutes were reported as an incident. Between 1 November 2015 and 30 September 2016 there were 44 incidents recorded of delays of more than 30 minutes in triage. None of these incidents showed any documented harm as a result. If a woman called more than three times in 24 hours they were invited in for assessment, as the service recognised this could be as a result of low mood or domestic violence.
- We observed three triage telephone calls, where women called in seeking advice. On one occasion a woman reported vaginal bleeding and was immediately advised to call an ambulance. The other two reported regular contractions and were advised to come in for assessment. In all the calls that we observed, the triage midwife asked for details of any medications taken and frequency of foetal movements.
- A process was in place if a woman arrived in labour without being pre-booked. Staff tried to find a bed in the delivery suite; however, if this was not possible, a safe delivery could occur within the triage area as an emergency delivery pack was kept on the unit.
- There was no high dependency unit within maternity. However, there was appropriate liaison with the critical care unit in the event that a patient required input from them. Staff on the delivery suite had a good working relationship with the critical care outreach team, who visited the ward when needed to assess and treat patients.
- The service used the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist during obstetric and gynaecological surgical procedures. We observed the surgical team going through the checklist during our unannounced inspection and reviewed four patient records that showed the WHO checklist had been signed appropriately. Observational audits were also completed to assess compliance with the WHO checklist. We reviewed the audit results from August 2015 to July 2016 and saw that obstetric and gynaecological procedures had 100% compliance with completion of the checklist.
- During our previous inspection in July 2015 we identified issues regarding cardiotocography (CTG) interpretation. As a result of this a patient care improvement plan (PCIP) to address this had been formulated. The service reviewed 37 sets of intrapartum (during delivery) notes in August 2016. This found that 88% of patients had a CTG review documented on all ward rounds. Out of these 59% always had a full systematic review and 91% had a two hourly 'fresh eyes' review (where a peer reviews the CTG trace), in accordance with classifications in NICE CG 190. During our inspection we reviewed seven sets of electronic CTG records and saw that three of these had not undergone fresh eye reviews every two hours as required.

Midwifery staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment, in line with relevant tools and guidance. The service used Birth Rate Plus, a national acuity tool, to assess staffing requirements. The tool was completed every four hours by the delivery suite coordinator and staffing levels were adjusted accordingly. Staff were flexed between the maternity wards to cover shortfall where required. We saw that a midwifery staffing establishment review was undertaken every 6 months and women in established labour generally received 1:1 care in accordance with NICE guidance (NG4).
- Two experienced midwives (band 7) were on shift on the delivery suite. One performed the role of delivery suite coordinator (managing all activity on the delivery suite) and the other was the unit coordinator (managing all activity on antenatal and postnatal wards and triage). The hospital was in the process of recruiting a consultant midwife, with the post advertised during our inspection. The post was to be a joint position with the local university, with a focus on both improving clinical practice and education.
- Actual staffing levels were often lower than planned levels. In August 2016 the service at the hospital had an overall average fill rate of day registered staff of 93% and an overall average fill rate of day unregistered staff of 100%. This meant that on average during the month there was not a full complement of midwives and

nurses, and that although they did have the correct number of midwifery support workers and healthcare assistants, extra assistants were not brought in to cover the shortfall in registered staff. For night shifts there was an overall average fill rate of registered staff of 92% and an overall average fill rate of unregistered staff of 88%. This meant that during August night shifts, the service never had a full complement of staff; either registered (nurses and midwives) or unregistered (midwifery support workers or healthcare assistants). Midwifery support workers on night shifts on the postnatal ward were consistently low throughout August, with less than 75% each week of the planned amount. During our inspection we saw that the postnatal ward was down two midwives for the late shift. The manager had increased the number of maternity support workers and had requested a midwife to be flexed to the ward to cover.

- Between September 2015 and August 2016, the hospital reported a bank and agency usage rate of 4% in the department. The service did not use any agency staff within the meadow birth centre or delivery suite. Agency staff were used in the GAU. We saw that agency staff were inducted to the ward on their first shift, and saw a completed form for an agency worker who had started work recently. However, the agency induction form did not have a date for when the induction had been carried out, a space for the name or post of the permanent staff member managing the induction process, nor a place for the new agency worker to sign. We were told by a manager that agency workers completed the checklist on their first shift, and did not repeat this, regardless of the length of time that had elapsed between shifts.
- There were arrangements in place for handovers at every shift change. Handovers occurred in private rooms to maintain patient confidentiality. We observed two handovers, one on the antenatal ward and one on the delivery suite and found both followed the SBAR (situation, background, assessment, recommendation) format well.
- All student midwives were supernumerary (not counted in the numbers), as was the delivery suite coordinator. Staffing numbers were displayed outside all inpatient areas.
- There was a birth rate ratio of one midwife to every 29 women. This was monitored monthly on the service's maternity dashboard. We reviewed the dashboard from July 2015 to July 2016. This indicated that the during the 12 month period the midwife to birth ratio had been one midwife to 30 births, with four months having a ratio of one midwife to 31 births (October 2015, November 2015, December 2015 and May 2016).
- Seven maternity support workers were required on each shift, to comply with safer staffing levels. However, there was an aim to have nine on duty to offer a greater level of care.
- There had been one maternity red flag event in December 2015. A red flag event is a sign that there may not be enough midwives available to provide safe care. This was acted on this by reallocating triage to the antenatal ward, reallocation of staff to triage and amending the patient flow pathway. Managers confirmed there were no red flag events for gynaecology.
- As of September 2016, there was a vacancy rate of 9% in maternity and gynaecology. Gynaecology specialist nurses (20%) had the highest vacancy rate, while the antenatal clinic had a vacancy rate of -6% indicating that the unit was overstaffed.
- Data supplied to us by the trust showed that in September 2016, there was a turnover rate of 11% within the maternity and gynaecology department.

Medical staffing

- The medical staffing skill mix was similar to the England average. There were 37% consultants, 7% middle career, 48% registrars and 8% junior doctors. In contrast, the England average was 40% consultants, 8% middle career, 45% registrars and 7% junior doctors.
- There was a middle grade vacancy rate of 40% and was struggling to recruit doctors to these posts, especially within gynaecology. The service had tried to recruit staff; however, uptake had been limited. As a result, there was a reliance on locum staff to cover gaps in the medical rotas. Between September 2015 and August 2016 the trust used 6% bank or locum staff.
- At the time of our inspection there had been four new consultants recently appointed, which meant that there were no current vacancies at consultant level.
- There had been 79 hours per week consultant cover in the delivery suite since April 2016. This was compliant with the RCOG safer childbirth guidance proportionate due to the number of births. The hours of dedicated consultant cover on the labour ward was marked as red on the service's maternity dashboard, as it was below the recommended best practice of 98 hours or more.

Consultant cover was provided 12 hours per day Monday to Friday (from 8am to 8pm), six hours per day on Saturdays and Sundays (8am to 2pm) and for one hour each night during the 10pm ward round. Out of hours consultant cover was provided on an on call basis, with the consultant based at home.

- A separate consultant covered the elective caesarean section lists, four days per week.
- Ward rounds occurred twice daily including bank holidays and weekends. We observed a ward round on the delivery suite and found it to be methodical and thorough, following an SBAR format.
- For gynaecology patients one consultant was on call for a 'hot week'; 24 hours a day for seven days. This meant that the same consultant reviewed the patients every day, which led to greater continuity of care.
- A duty anaesthetist was on duty 24 hours a day, seven days a week in accordance with the Association of Anaesthetists of Great Britain and Ireland guidance.
- On the delivery suite we saw that a SBAR handover had recently been introduced in October 2016. Attendees at the handover were signed in on a register. We saw that on 14 November 2015 only three out of 15 staff members attended, however, all other registers showed good attendance at the handover.

Major incident awareness and training

- We requested a copy of the service's major incident policy. However, the trust did not provide us with a copy.
- Arrangements were in place in case of suspension of maternity services, with escalation to board level and arrangements in place with local hospitals.
- We spoke with one patient on the postnatal ward who was transferred to the hospital from another local trust in pre-term labour due to their NICU being closed. The hospital transfer was swift and beds arranged in the NICU for the premature babies.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- Patient outcomes were mixed, with the service performing worse than their target in four performance indicators.
- Three out of four indicators in the National Neonatal Audit had not been met.
- Audits with regards to the care of women who had undergone a termination of pregnancies, had not been carried out, so there was no data on its effectiveness.
- The service did not audit the completion of their maternal early warning score; Worcestershire Obstetric Warning score, so there was no compliance data on this.
- Trust figures for mental capacity training was low, at 37%.

However:

- The service was awarded the UNICEF Baby Friendly Initiative level 3 for their promotion of breastfeeding. There were two infant feeding coordinator midwives employed, to assist women in establishing breastfeeding.
- There was compliance with NICE guidance on obstetric care.
- Pain was assessed and managed well. The Meadow birth centre offered alternative therapies for pain relief, including massage and aromatherapy.
- New clinical pathways were introduced two weeks before our inspection. However, as they had only been introduced, they were not yet embedded and staff awareness of how to access them were limited.
- There was positive multidisciplinary working with other specialities in the hospital.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. At the time of our inspection the service had recently changed their policies and guidelines over to pathways. The pathways referenced National Institute for Health and Care Excellence (NICE) and Royal College of Midwifery guidance appropriately. As they had only been introduced two weeks before our inspection the pathways were not embedded into practice and staff awareness of how to find the correct pathway was limited.
- There was adherence to NICE quality standards. Local audits showed that there was full compliance with NICE QS 22 (antenatal care), QS 32 (caesarean section), QS 35

(hypertension in pregnancy), QS 37 (postnatal care), QS 46 (multiple pregnancies), QS 47 (heavy menstrual bleeding), QS 60 (induction of labour), QS 77 (urinary incontinence in women) and QS 115 (antenatal and post-natal health). The service was awaiting formal assessment for their compliance with QS 98 (nutrition) and QS 105 (intrapartum care), but provided evidence of local pathways to show their work in these areas.

- NICE guidance on caesarean section (QS32) was adhered to. We saw that women were offered a chance to have a vaginal birth after a previous caesarean section (VBAC) for their subsequent children. Women who had caesarean sections were also monitored for any postoperative complications with a consultant review scheduled for the first day in the postnatal ward following the birth. Specialist VBAC clinics were held antenatally to ensure women were given adequate information regarding delivery mode.
- The service was compliant with NICE guidance on antenatal and postnatal mental health (CG192). Mental health antenatal clinics were held every two weeks, ran by community psychiatric nurses and a mental health clinic lead nurse. The delivery suite and postnatal ward liaised regularly with the crisis outreach team, who visited women on the ward and conducted mental health assessments if needed.
- A diabetes antenatal clinic was run by a diabetes link midwife. Women at the clinic were offered glucose tolerance testing, in line with NICE guidance (NG3).
- In the 2014 National Neonatal Audit (NNAP) the hospital failed to meet the standards for three out of four indicators; babies of less than 28 weeks gestation having their temperature taken within an hour of birth (88%), babies with gestation age of less than 32 weeks or weighing less than 1501grams at birth undergoing retinopathy of prematurity screening in accordance with national guidelines (92%) and documented consultation with parents by a senior member of the neonatal team within 24 hours of admission (90%). For all three standards the target rate was 100%. The hospital met one standard; babies delivered between 24+0 and 34+6 gestation given a dose of antenatal steroids (92%), exceeding the target of 85%. The hospital was also below the NNAP benchmark regarding the proportion of babies less than 33 weeks gestation receiving maternal milk when discharged from the neonatal unit. The hospital met this standard in 58% of cases, just below the benchmark of 60%. We requested a copy of the service's action plan to improve this; however, they did not provide us with a copy.
- Technology and equipment was used to enhance the delivery of effective care and treatment. In the delivery suite electronic screens showing cardiotocography (CTG) traces were displayed in the midwives' station so that midwives and doctors could review the traces from outside the room. This was an improvement from the previous inspection, when the boards were not visible at the main station. Uplighters and scented diffusers were used in the Meadow birth centre to maintain a relaxing and calming environment for births.
- Women with multiple pregnancies were planned and provided for in accordance with NICE guidance on management of twin and triplet pregnancies. There was a pathway regarding the care of these women and a twin pregnancy midwife who was involved in their care.
- Growth was monitored from 24 weeks by measuring and recording the symphysis fundal height (from the top of the mother's uterus to the top of the mother's pubic bone) at each midwifery appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 guidance. If concerns arose regarding foetal growth the patient was referred to triage for a full assessment.
- Midwives and obstetricians emphasised the importance of foetal movements at each antenatal contact in accordance with MBRRACE-UK 2015 and RCOG guidance. This was emphasised to women during antenatal clinics and we saw posters displaying this information in both the antenatal clinic and triage. During the triage telephone conversations we saw that the midwives asked about foetal movements when assessing whether the woman needed to attend.
- The guideline for termination of pregnancies for foetal anomalies was based on RCOG guidance. Follow up appointments were made with the women to discuss the chance of reoccurrence of the medical abnormality and to discuss plans for any future pregnancies. However, audits of care of women undergoing termination of pregnancies were not undertaken and therefore there was no numerical data to support compliance with the guidance.
- The trust confirmed that they did not submit to the NICE shared learning database. This meant that there was no evidence of cross sharing of information and best practice, with other NHS trusts.

Maternity and gynaecology

Pain relief

- Pain was assessed and managed well across both maternity and gynaecology. Women in labour had their pain assessed regularly and were given a choice of both pharmacological (medicines) and non-pharmacological pain relief.
- In the Meadow birth centre women were offered alternative therapies for pain relief, including massage and aromatherapy. Pethidine was also offered, if requested. In the delivery suite women were offered Entonox, which was piped into the delivery rooms, In addition, epidurals were available, if requested.
- There was an anaesthetist on duty 24 hours a day to ensure that women requesting epidurals could receive them at any time. We requested details on the time taken between women requesting an epidural and then receiving them. Guidance states this should be no longer than 30 minutes. However, the trust did not provide us with this data, so we were unable to see if they were compliant with guidance.
- The women we spoke with all told us that their pain needs were managed well.
- Women were given information about the availability of different types of analgesia (pain relief) antenatally, in accordance with AAGBI obstetric anaesthetic guidance. Women were informed that certain forms of pharmacological pain relief was not available within the meadow birth centre, such as an epidural, and that if they wanted it they would have to give birth in the delivery suite.
- During and after termination of pregnancies, women received effective pain relief, in line with RCOG guidance. For women who presented with ectopic pregnancies, non-steroidal pain relief and codeine was given on an as and when needed basis. Women who experienced a miscarriage were offered opioids and patient controlled analgesia if required.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and met. We saw fluid balance charts completed where appropriate, and saw food being offered and served to women at meal times. Patients we spoke with told us that the food and drink provided was of an acceptable standard and that portion sizes were good.
- Snacks were available outside of meal times. We observed a patient and her partner being offered tea and biscuits on arrival on the antenatal ward.
- The service supported new mothers in feeding their babies as they chose. Two infant feeding coordinator midwives were employed, who helped new mothers learn to breastfeed their child. The service had been awarded the UNICEF Baby Friendly Initiative level 3. The baby friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. We saw posters displayed on the postnatal ward and antenatal clinic promoting the importance of breastfeeding and stickers were placed in women's hand held maternity notes highlighting the health benefits associated with breastfeeding.
- The infant feeding coordinator was qualified to divide tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers. For mothers who wished not to breastfeed, formula milk was provided.
- Women we spoke with on the postnatal ward told us they felt well supported in attempting to establish breastfeeding, particularly from the student midwives on duty, whom the women found to be encouraging and supportive.
- From July 2015 to June 2016 on average 71% of women breastfed following delivery. During the same reporting period, the number of women who breastfed at discharge from hospital fell to 65%. This was below the national target of 74%. There was an action plan in place for improving their performance in this area, which was focused on ensuring accurate data collection and improving discussions during antenatal care. In addition, trained breastfeeding volunteers in the antenatal period had been introduced.
- Women in low risk labours were encouraged to eat and drink during labour. Women in high risk labours were put on an intravenous fluid infusion to ensure they did not dehydrate, whilst ensuring that safety was maintained if the need occurred for an emergency caesarean section.

Patient outcomes

- Information about the outcomes of maternity patients' care and treatment was not always routinely collected and monitored.

Maternity and gynaecology

- Between April 2015 and March 2016 there were 5,598 deliveries at the hospital. Of these births, 99% were single deliveries and 1% were multiple deliveries. Normal (non-assisted) deliveries accounted for 3,356 births from April 2015 to March 2016, which was 60% of all births, the same as the England average. In the same reporting period there were 1621 caesarean section deliveries, which accounted for 29% of births. There was low use of forceps deliveries; 8%, and 3% were ventouse deliveries. Between April 2015 and March 2016 the total number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections was higher than expected and rates for emergency sections similar to expected. Work had been done to lower the rate of elective caesarean sections and this was no longer out of the expected range, with the rate being below the national average in August, September and October 2016.
- The information showed that the intended outcomes for patients were sometimes achieved; however, the results were mixed. Some audits had attached action plans; however, not all of these evidenced an improvement in practice.
- During the same reporting period there were 35 cases of third or fourth degree tears (severe tears in the vaginal tissue, perineal skin and perineal muscles), higher than the national target of less than 10. There was an action plan in place to reduce the number of tears, which focused on rolling audits, and providing training on minimising tears. However, the action plan provided was dated January 2015 and actions were marked as completed in March 2015. However, as the high incidence of tears noted were from April 2015 and March 2016 there was no evidence that this action plan improved practice.
- There had been four admissions from obstetrics to the intensive care unit from April to July 2016. This was higher than the hospital's target of two admissions. The admissions were due to two major obstetric haemorrhages, one patient suffering acidosis following a caesarean section and one patient requiring a blood transfusion following manual removal of placenta following normal vaginal delivery.
- We reviewed the 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK) perinatal mortality surveillance report for births between January and December 2014 (published in May 2016). The report stated that the service had a crude neonatal death rate of 1.75 per 1,000 live births, which was up to 10% higher than the UK average. This equated to 10 neonatal deaths. The report also identified the level of completeness of the data the service provided to MBBRACE. Recommendation 8 of MBBRACE states that trusts must report all baby outcomes, including late foetal losses where births occur between 22 weeks and 23 weeks and six days where the infant does not survive the neonatal period (28 days). The report stated that the trust reported 100% of all baby outcomes.
- There was one maternal death in the summer of 2016. The national target is to have zero maternal deaths. We reviewed the MBRRACE report into the maternal death and saw that the patient had complex comorbidities which led to respiratory and cardiac arrest at home. No hospital factors impacted on the patient's outcome.
- Between April 2016 and September 2016, there were 145 category one (emergency) caesarean sections at the service. Of these 145 women, 72% had regional anaesthesia (epidural or spinal tap) and 28% had general anaesthesia. This did not meet the 'Safer Childbirth' guidance which stated that 85% of women undergoing emergency caesareans should have regional anaesthesia.
- There was poor performance in relation to antenatal detection of intrauterine growth restriction (a condition where an unborn baby does not grow at a normal rate). From April to July 2016 this was identified in 16% of cases, significantly lower than the target of 40%. The service's action plan to improve compliance in this outcome included continuation of GROW training (customised antenatal growth plotting) with the Perinatal Institute, the introduction of NHS England's 'Saving Babies Lives' care bundle, offering smoking cessation advice to patients and continuing to monitor early booking to establish foetal age.
- Audits of compliance with the UK National Screening Committee's standards for screening programmes had been carried out. The audit considered 26 pairs of hand held and newborn notes and assessed whether these notes had evidence of screening for sickle cell and thalassaemia screening (SCT), infectious disease screening (IDSP), foetal anomaly screening (FAS), newborn blood spot screening (NBBS), newborn infant physical examination (NIPE) and newborn hearing screening (NHSP). The audit found that in almost all (25 out of 26) records reviewed, screening information was

provided to women. It also found that between 24 and 26 records had documented offers of screening tests for SCT, IDSP, FAS and NBBS. However, none of the 26 records reviewed had documented offers of screening for NIPE and NHSP.

- Between April 2015 and March 2016, there were 29 stillbirths, an increase from the previous year by five. The number of early neonatal deaths had also increased; from 12 to 13. The service had an ongoing relationship with the West Midlands Perinatal Institute. The institute used a standardised approach for reducing perinatal and still births through standardising case notes and using customised growth charts. Training was also provided in fundal height measurement, plotting scan measurements and dating scans before 12 weeks. The service maintained that their stillbirth rate and neonatal death rate was equal to or below England average, as per the West Midlands Perinatal Morality report (March 2016). A gap analysis had also been completed, as a result of the introduction of the 'Saving Babies Lives' bundle. This had identified that additional scans were required for high risk women. Training midwives in this area had commenced.
- There was an increased number of unexpected admissions to the neonatal intensive care unit; from 588 in April 2014 to March 2015, to 616 from April 2015 to March 2016. Unexpected admissions to the neonatal unit became a CQUIN in 2016. Although the service performed well in this target against other local units, it identified that the two main causes for avoidable admissions were babies being cold, which resulted in respiratory problems and babies with hypoglycaemia who required glucose treatment. As a result, a concentrated dextrose gel to treat babies quickly was introduced and a neonatal nurse was put onto the transitional care unit to manage babies without the need for admission.
- From 1 June 2016 to 31 August 2016 66 VBACs were attempted, of which 44 were successful. Out of the 44 successful VBACs 37 ended in spontaneous vaginal deliveries, five were forceps deliveries and two were ventouse deliveries.
- There was good performance in the number of full term babies admitted to neonatal intensive care. From April 2016 to July 2016 2% of babies were admitted, lower than the national target of less than 5%. This was due to the development of the transitional care unit. This unit allowed babies which required some further support, for example if they had jaundice, to stay in hospital with their mother, without the need for transfer to neonatal intensive care.
- From April 2016 to July 2016, 11% of women were reported to be smoking at delivery. This was better than the national target of 12% and better than the previous year, which had been 13%. This was due to support given during antenatal clinics and referrals to smoking cessation support groups.
- The percentage of failed termination of pregnancies was not audited; therefore, no data was available on patient outcomes in this area.
- We were informed that the service had not collected safety thermometer data since May 2016 as a result of personnel change. This meant the service could not evidence patient outcomes in these areas.

Competent staff

- Staff generally had the right qualifications, skills, knowledge and experience to do their job. Midwifery staff completed their preceptorship when starting as newly qualified midwives. However, gynaecology patients being treated and cared for on Chestnut surgical ward, or other outlying wards, were not cared for by gynaecology trained nurses. The bereavement midwife had provided some training to the nurses on Chestnut ward on how to deal with the sensitive disposal of foetal remains.
- Midwives with appropriate competencies scrubbed for obstetric operations, but did not care for patients in recovery. These patients were cared for by dedicated recovery nurses. Two midwife champions were leading staff through midwifery scrub competencies. At the time of our inspection half of the midwifery staff had completed competencies in this area. Midwives only scrubbed for emergency procedures.
- Two band 4 posts had been recently introduced, who were trained to scrub for elective lists. Due to the staff being new in post they were supported by band 5 scrub nurses at the time of our inspection.
- Learning needs of staff were identified through annual personal development reviews and in response to incidents if poor practice was identified. We saw training courses were scheduled for suturing (stitches) workshops and safeguarding.

- Staff were encouraged and given opportunities to develop. Some staff we spoke with were in 'acting up' development roles, with recruitment ongoing for these to be turned into substantive posts.
- Arrangements were in place for supporting and managing staff. One to one sessions were held at the same time as the annual personal development reviews, although we were told they happened more frequently if staff expressed a need for them.
- Between April 2015 and March 2016 87% of staff had undergone an appraisal, meeting the target of 85%.
- The service's supervisor to midwife ratio from July 2015 to July 2016 was one supervisor to 20 midwives, above the Nursing and Midwifery Council's target of one supervisor to 15 midwives. All midwives had a supervisor allocated who supported them in their clinical practice.
- CTG training had been incorporated into their biannual maternity specific mandatory training. CTG interpretation meetings were also held weekly in the department; however, some staff said they struggled to get the time to attend these. Plans were in place to train more midwives in newborn infant physical examination (NIPE) and seven out of 16 midwives on the meadow birth centre had completed this at the time of our inspection.
- The bereavement midwife offered services to all women who had suffered pregnancy loss or termination or pregnancy over 12 week's gestation. However, the midwife did not offer formal therapeutic counselling as the trust did not provide this. The midwife referred patients needing such counselling to local charities or GPs who offered such support.
- RCOG 'Safer Childbirth' guidance states that there must be someone with neonatal life support (NLS) available immediately at all times. Basic neonatal resuscitation was part of the maternity mandatory training, which had a 95% compliance rate. Across the service 41% of midwives had completed NLS. All midwives on the meadow birth centre were trained in NLS and all junior paediatric doctors completed NLS before starting their placement within maternity.

Multidisciplinary working

- The maternity service promoted multidisciplinary working. We saw positive interactions between community midwives, hospital midwives and support workers, doctors, social services and physiotherapy.
- Two physiotherapists attended the postnatal ward every day. Physiotherapists supported women following caesarean sections and third and fourth degree tears. They were involved in ensuring the women were able to walk around and get in and out of bed and aimed to limit discomfort as possible after birth. Women with third or fourth degree tears were given the physiotherapy telephone number for telephone advice, which they could use, once they had been discharged from hospital care. All women who had third or fourth degree tears were seen at a follow up clinic after the birth.
- We saw examples of joint working with social services in cases where safeguarding concerns had arisen. We saw that midwives were involved in the child protection conferences and were kept updated with progress on care protection plans.
- We also saw evidence of multidisciplinary working when planning for an elective caesarean section for a patient with physical disabilities. Midwifery and medical staff had worked closely with porters and estates to ensure that all areas of the patient's care, including transfer to the delivery suite and showering arrangements, were met.
- There was positive multidisciplinary working with the mental health team, with antenatal mental health clinics being held every two weeks. A perinatal mental health team also operated Monday to Friday, who had often been made aware of any patients who might require their services.
- There were positive working relationships with the neonatal intensive care unit, with women supported to visit their baby from the postnatal ward.
- Patients were discharged from the service at an appropriate time of day and after relevant teams and services had been informed. We observed one patient who had given birth in the early hours of the morning on the Meadow birth centre staying in the centre longer than clinically needed in order to ensure an appropriate discharge time. We also observed a patient in the transitional care unit being advised on the need to inform their GP of the birth of their child.
- There was access to other specialities during a patient's stay on maternity unit, including a diabetes midwife, a safeguarding midwife, a scanning midwife, a screening midwife and a bereavement midwife. This ensured that women had all of their needs met during their stay in the hospital.

- Community midwives were employed by the same trust as the hospital midwives. Community midwives were on occasion flexed to cover shifts in the hospital which meant that links were forged within both teams. When a patient was discharged, staff sent a copy of the discharge letter to the community midwives.
- Following a termination of pregnancy detailed discharge letters were sent to the patient's GP to inform them of the procedure and any associated risks.

Seven-day services

- Maternity and gynaecology services were available 24 hours a day, seven days a week. Triage was open all hours to provide maternity assessment, with the gynaecology assessment unit providing the same for gynaecology patients. All inpatient wards, including the antenatal ward, Meadow birth centre, delivery suite, postnatal ward and transitional care unit were open 24 hours a day seven days a week.
- The early pregnancy unit and maternity day assessment unit were open Monday to Friday 9am to 9pm. Out of hours patients were seen by either triage or the gynaecology assessment unit, depending on the woman's gestation.
- Consultant cover was provided 12 hours per day Monday to Friday (from 8am to 8pm), six hours per day on Saturdays and Sundays (8am to 2pm) and for one hour each night during the 10pm ward round. Out of hours consultant cover was provided on an on call basis, with the consultant based at home.
- For gynaecology patients one consultant was on call for a 'hot week'; 24 hours a day for seven days. This meant that the same consultant reviewed patients every day which led to greater continuity of care.
- The service had five scanning midwives who were trained in scanning and imaging. These midwives were able to provide this service out of hours. The gynaecology consultant who was on the 'hot week' also provided a scanning service to patients, which was available 24 hours a day if required.
- Pharmacy support was available from Monday to Friday 8.30am to 5.30pm and on Saturdays from 9am to 12:30pm. Outside of these hours staff accessed medications by using either the medicines locator electronic system or by contacting the bleep holder who had access to the emergency store.

Access to information

- Information needed to deliver effective care and treatment available to relevant staff was usually available in a timely and accessible way.
- Whiteboards were displayed in the delivery suite, antenatal ward and Meadow birth centre. In order to maintain confidentiality women were identified by their initials, their condition, such as dilation, gestation and any other important factors such as twin delivery. This ensured that all staff knew which patient was in what room, with clear identification of their clinical picture.
- Antenatal and postnatal notes and records from the Meadow birth centre were paper based, whereas records from the delivery suite and triage were electronic. This meant that women's paper records did not always have a full picture of their care and treatment if they were seen by triage or the delivery suite. However, all staff appeared confident in using the electronic system to find the records and this system seemed well embedded.
- Each room in the delivery suite had a computer to document electronic records. Staff on the midwife station could also access the system through their computers there, which meant that midwives caring for women in the room could add notes or review the documentation, when not in the delivery room.
- When a woman was discharged, it was communicated to GPs electronically. A copy of the discharge letter was also given to the patient, one kept in the notes and one faxed to the community midwifery team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance including the Mental Capacity Act 2005. They told us that if they had any concerns regarding a patient's mental capacity they would contact the safeguarding midwife for advice.
- Women gave verbal consent for some of their care and treatment, such as vaginal examinations, episiotomy and suturing. This was recorded on the electronic system in the delivery suite. We reviewed three records and saw consent was obtained and documented prior to vaginal examination and episiotomy.
- Women undergoing obstetric or gynaecology operations gave written consent and we saw examples of this in the records we reviewed.

- Consent to obstetric treatment was documented on the hospital's electronic system. We reviewed the hospital's internal audit for this, which covered deliveries from September 2015 to August 2016. For forceps deliveries, all but one (354 out of 355 deliveries) had consent documented on the system, and for the remaining one the reason for the lack of consent had been documented. All ventouse deliveries had documented consent on the system. Out of the 1534 caesarean section deliveries, consent was documented in 1511 cases. Out of the 23 remaining deliveries, 10 of these had the consent documented elsewhere and six had the reason for the lack of consent documented. The service was unable to provide an explanation for the remaining seven notes. As a result of the findings reminders were circulated to staff regarding the importance of documenting consent and was included in the system's update sessions.
- The trust reported that as of September 2016 37% of staff had completed MCA and DOLs training.
- As the service only performed termination of pregnancies for foetal anomalies they provided clear information to women to ensure they understood the implications of their decision.
- We were assured that all terminations of pregnancies had the authorisation of two doctors, in compliance with the Abortion Act 1967. Due to the limited number of terminations carried out by the hospital annually (21), at the time of our inspection only one had taken place recently and therefore only one set of notes were accessible in the gynaecology assessment unit. We reviewed the set of notes and saw that the HSA1 form was completed appropriately, with two doctors' signatures and the reason for the termination highlighted. The parents had also signed the consent form for the procedure and for the sensitive disposal of the pregnancy remains.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- The service's Friends and Family Test exceeded the national average for all indicators.
- The bereavement midwife offered a comprehensive service to women and their families suffering from pregnancy loss or stillbirth. In addition, they offered individualised care and provided telephone and home visits to families who wanted them.
- Staff interacted well with patients, offering compassionate and kind care.
- All patient feedback we received on inspection was positive, with patients praising the staff caring for them.
- Privacy and dignity was maintained, with staff always asking before entering a patent's bed space.
- Staff communicated with patients so that they understood their care and treatment. Patients told us they were given choices in their care and treatment where appropriate.

Compassionate care

- Staff took the time to interact with patients and those close to them in a respectful and considerate way. We observed positive interactions between staff of all levels and patients, showing compassion and encouragement to women.
- Women we spoke with were positive about the care and treatment they had received. Patients told us that they could not fault the staff and that they had been attentive to all of their needs. One patient told us how a midwife had requested to continue caring for her due to the relationship that had been built up during her stay. The patient was very thankful for this continuity and the connection that had been formed.
- Staff ensured that patients' privacy and dignity was respected and maintained. For patients in private rooms staff knocked on the door before entering and curtains were used on bays to ensure patients privacy.
- Appropriate help and support was given to mothers in labour before arrival, when they contacted the labour ward. We observed three triage telephone calls and saw kind and sympathetic care from the midwives, offering advice on how to alleviate pain at home whilst ensuring that women felt able to come in for assessment if they needed to.
- The maternity Friends and Family Test (FFT) exceeded the national average for all indicators in August 2016. These covered the percentage of patients who would recommend antenatal care (99%), birth care (100%), postnatal care (98%) and postnatal community care (100%).

- We reviewed the patient guestbook in the Meadow birth centre and saw multiple examples of positive feedback and thanks from women and their relatives. We saw many women had commented positively on the difference between their previous birthing experiences at the hospital and their time in the Meadow birth centre.
- The maternity service had participated in the CQC survey of women's experiences in maternity. The 2015 survey showed that the service was better than other trusts in three indicators; being given sufficient information following childbirth, the cleanliness of the room and ward and being treated with kindness and understanding after birth. The service was worse than other trusts in one indicator; being able to move around and choose a comfortable position during labour. For all remaining indicators the service performed about the same as other trusts.
- We reviewed the Picker Institute Europe's maternity survey, published in October 2015. This showed that maternity care at the hospital was significantly better than the average trust score for being treated with kindness and understanding (14% better than the average), receiving help and advice about feeding (16% better than the average) and being seen by a staff member in a reasonable time (13% better than the average). However, the service scored significantly worse than the average regarding the patient being able to have a loved one stay with them as long as they wanted following the birth (6% worse than the average). On inspection we saw that birth partners were allowed to stay with women at all times in the Meadow birth centre and the delivery suite.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. Patients we spoke with confirmed that information was given to them in easy to understand formats and that they felt able to ask questions if they needed any further clarification.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and they enabled them to access this. There was access to translators and sign language specialists and staff gave examples of times when they had been used. The safeguarding midwife was utilised to provide extra support to women with a learning disability.
- Patients and those close to them were routinely involved in planning and making decisions about their care and treatment. Patients we spoke with confirmed that they were given choices in their care and treatment where appropriate and all staff displayed a patient centred approach.
- The Picker Institute Europe's maternity survey 2015 also showed that the service was significantly better than the average in giving consistent advice (8% better than the average), giving postnatal women information about their recovery following the birth (13% better than the average) and receiving help and advice about their baby's health and progress (11% better than the average). However, scored lower than average on being involved in decisions about care (7% lower than the average).
- Discussions were held antenatally about the woman's choice of birth location and the benefits and risks of each location. The service had identified that a lot of women wanted to give birth in the Meadow birth centre, but did not meet its risk based criteria for admission. As a result the team leader on the unit had developed biweekly antenatal clinics with this group of women, to assess their risk level and eligibility individually. This led to more women being able to give birth in the Meadow birth centre; their preferred location of choice and led to greater involvement of women.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them. For women experiencing pregnancy loss over 12 weeks gestation the bereavement midwife offered a variety of support. This included miscarriage, stillbirth or termination of pregnancy for medical abnormalities. The delivery suite had a ring fenced bereavement suite, which women over 16 week's gestation were able to use. The bereavement suite had cold cots to allow women and their families to spend time with their baby. The bereavement midwife also offered individualised memory making sessions and brought in a professional bereavement photographer to take photos of the baby for free, if the parents wanted.

Maternity and gynaecology

- In cases of maternal deaths which were referred to the coroner's court, the bereavement midwife remained in regular contact until after the judgement. Contact was provided both over the telephone and home visits. The bereavement midwife also helped families with funeral arrangements and had changed the unit's contract to three funeral directors located across the catchment area to ensure that parents did not have to travel far to make the necessary arrangements.
- If women required further support then the bereavement midwife referred them to their GP for counselling, as no formal counselling was offered by the trust.
- The perinatal mental health team provided assessment for women at risk of postnatal depression or anxiety. This service was provided Monday to Friday. Out of hours mental health assessments were provided by the mental health crisis team.
- The Picker Institute Europe's maternity survey 2015 showed that the service was significantly better than the average in giving information about emotional changes following birth (11% better than average).
- Patients were enabled to have contact with loved ones and their social networks. Visiting hours on the postnatal ward was from 10am to 10pm for birth partners and women's children, and 3pm to 4pm and 6pm to 8pm for other relatives and friends.
- Women on the postnatal ward were offered emotional support when trying to establish breastfeeding. There were two breastfeeding specialist midwives and breastfeeding support volunteers who provided emotional support and encouragement to women on the postnatal ward who were trying to establish breastfeeding. Women we spoke with were very complimentary about this service and the assistance it provided in the first few days of establishing breastfeeding.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The referral to treatment time for gynaecology patients had declined and was below the national indicator of 90%, with the service achieving this in 80% of cases.
- The six nominated gynaecology beds on Chestnut surgical ward were not ring fenced and so were often occupied by other patients. This meant gynaecology patients were often nursed on general medical wards.
- The waiting room and toilet facilities for patients using the gynaecology assessment unit were mixed sex as these were shared with a respiratory outpatient clinic.
- There were no specific arrangements for caring for women with a learning disability.

However:

- The safeguarding midwife provided care and support to women with safeguarding concerns or who misused alcohol or drugs. These women then stayed in the transitional care unit following birth to provide extra support.
- Triage worked effectively, signposting women to the various departments depending on their condition and gestation.
- Although the majority of leaflets displayed were in English, a telephone number was provided for translation services and some leaflets were written in Polish.
- Facilities for partners to stay had increased on the Meadow birth centre, delivery suite and side rooms on the postnatal ward.

Service planning and delivery to meet the needs of local people

- In November 2015 the maternity inpatient service was centralised, with all inpatient activity and deliveries moving from being across three sites, to just one; Worcestershire Royal Hospital. This had led to some concerns in the community regarding the potential for women in labour to give birth before arrival, due to the extra travel time. However, data from the service indicated that there had been no increase in the amount of babies born before arrival as a result of the centralisation.
- Gynaecology services were not always responsive to patient's needs. There was no gynaecology ward at the hospital, which meant that patients were placed in a number of wards. There were four ring fenced beds for gynaecology patients on the antenatal ward and six nominated beds on the mixed sex Chestnut surgical

ward, although these were not ring fenced and medical outliers occupied these beds on occasion. Due to bed pressures gynaecology patients also stayed overnight in the gynaecology assessment unit, an outpatient clinic, which did not have appropriate facilities such as a shower and single sex toilet, for inpatient stays.

- The waiting room for the gynaecology assessment unit was shared with the mixed sex respiratory outpatient clinic. This meant that women experiencing miscarriage or ectopic pregnancies had to wait in a mixed waiting room and there were no private waiting rooms
- The services provided, reflected the needs of the population served and ensured flexibility, choice and continuity of care. During our previous inspection we noted that the day assessment unit could only see one woman at a time, leading to issues with efficiency. On this inspection we saw that the service had increased the capacity of the day assessment unit to three people, to improve service delivery. Care was provided for women in all stages of pregnancy, with women under 12 weeks gestation being seen in the early pregnancy unit, between 12 and 20 weeks by the gynaecology assessment unit, and over 20 weeks by the delivery suite.
- There was a gynaecology consultant on call 24 hours a day, seven days a week. This ensured that consultant cover for gynaecology patients across the hospital was consistent and ensured continuity of care.
- Facilities for relatives and partners to stay had increased, with facilities available on the Meadow birth centre, the delivery suite and on side rooms in the postnatal ward. There were no facilities available for women experiencing miscarriages to have relatives and partners stay overnight as they were often nursed in general medical wards.
- Quarterly meetings with the maternity service liaison committee were held, to design services to meet the needs of women. Both the matron and the manager of the Meadow birth centre attended.

Access and flow

- Women accessed the maternity services via their GP, by contacting the community midwives or by contacting the hospital directly. Gynaecology patients accessed the service through GP referral, walk in attendance at the gynaecology assessment unit or via the emergency department.
- Patients did not always have timely access to initial assessment, diagnosis or treatment. The referral to treatment time (RTT) for gynaecological procedures was below the indicator of 90%. RTT is no longer a national target, it is now used just as an indicator of care. The RTT times have declined since January 2016; from 87%, to September 2016; 80%. Managers said this was a result of trust wide pressures on elective beds and the reduction of middle and junior grade medical staff. In order to improve this, an action plan had been implemented in which GP referral letters were triaged by a consultant, additional consultant clinics were offered, and outsourcing of gynaecology services was also being explored.
- The number of gynaecological outpatient appointment 'did not attend' rates varied between 5% and 12%.
- Performance with regards to the two week cancer wait for suspected cancers was good. From October 2015 to October 2016 the service met or exceeded the target of 93% in 11 out of 13 months.
- Performance was also good for the 31 day wait for first treatment for all cancers. From October 2015 to October 2016 the service met or exceeded the target of 96% in 12 out of 13 months.
- However, the service performed badly in the 62 day wait for first treatment from urgent GP referral for all cancers. From October 2015 to October 2016 there was a failure to meet the target of 85% in 10 out of 13 months.
- We requested details on the number of elective procedures that were cancelled. The trust only provided us with data regarding the number of procedures cancelled that were not rearranged, not the number overall that had been cancelled.
- We requested the number of gynaecological outliers; however, the trust did not provide us with this data. Gynaecology outliers were reviewed by a consultant every day of their stay. Due to the gynaecology hot week consultant cover (where the same consultant was on duty 24 hours a day for one week), patients were seen by the same consultant every day, unless they were in over the weekly change over period.
- The staff working within the triage suite liaised closely with the delivery suite to ensure women were not in labour and giving birth in inappropriate areas, such as triage. We observed the triage team liaising with the delivery suite coordinator about expected incoming patients and arrangements were made to move women who had already delivered to the postnatal ward to

make an available bed. An emergency delivery pack was held within triage in the event that a delivery took place there. Women who had contacted triage and were already in established labour were directed to the delivery suite.

- Maternity patients were triaged effectively and if in labour, sent to either the Meadow birth centre if they were low risk or to the delivery suite if they were high risk. The triage suite prioritised patients waiting to be seen based on clinical need and symptoms. The staff in triage aimed to assess all patients within 30 minutes of attendance and any delays of over 30 minutes were reported on the electronic incident reporting system. Between June 2016 and October 2016 on average 8% of women waited longer than 30 minutes for midwifery triage. However, these case files were reviewed and all women who waited longer than 30 minutes were classified as non-urgent, for example, awaiting a scan review.
- Patients were seen regularly throughout their pregnancy, in accordance with the standard pattern of antenatal appointments. Attendance for high risk patients was monitored and patients who did not attend appointments were contacted and appointments rebooked as necessary.
- We requested the number of delayed planned inductions. However, we were informed us that they did not routinely collect this data.
- Women were given the direct telephone number of the gynaecology assessment unit, which was open 24 hours a day, seven days a week, to all women following termination of pregnancy. They were advised to contact the dedicated number if they had any concerns following discharge. This was in line with DH RSOPs guidance.
- As termination of pregnancies were not audited, we were unable to see how many women were offered a termination within five working days of their decision.
- Between April 2015 and April 2016 the bed occupancy levels were generally lower than the England average. The hospital's bed occupancy rates in January 2016 to March 2016 were 54%, lower than the England average of 61%.
- From April to November 2016 2,269 women were booked for antenatal care before 10 weeks and six days. Between the same time scale 3,407 women were booked before 12 weeks and six days. This meant that 1,138 women were booked between 11 weeks and 12 weeks and six days. National Institute for Health and Care Excellence guidance CG162 states that women should ideally access antenatal care before 10 weeks. Between January 2016 and November 2016 91% of patients booked within 12 weeks and six days. The main reason for late booking was a late referral to midwife (328 patients), patient transferred from another area (116 patients) and previous appointment cancelled by patient (52 patients).

Meeting people's individual needs

- Arrangements were in place for patients who need translation. We saw evidence in patient notes that translation requirements were identified at antenatal appointments and translators were arranged to be present when required. Although the majority of leaflets displayed were in English, they did have details of how to get these translated. We saw one leaflet available in Polish on the induction of labour. The postnatal ward had a folder of common postnatal questions written in both English and Polish to aid communication. We were told that Polish speakers were the biggest minority in the area who used the services.
- There were no specific arrangements in place for women with a learning disability. There was no specific learning disability pathway and no access to any learning disability communication aids.
- A safeguarding midwife was employed, who cared for women with complex issues such as substance and alcohol misuse. These women stayed in the transitional care unit following the birth of their baby, to ensure that the baby was not experiencing alcohol or drug withdrawal symptoms and to observe the care provided by the mother to their baby. Arrangements were in place with local authorities and social services for referral if needed.
- Patients aged over 65 within gynaecology were assessed to see if they were living with dementia. There was a specialist dementia nurse in post, who assisted where necessary and a 'This is me' dementia booklet was completed to ensure staff knew about the wishes and preferences of the patient.
- Post mortems were offered in all cases of stillbirth and neonatal deaths in order to assist in any future pregnancies. Placental histology was also available and took place with the woman's consent. We saw evidence of this in the records we reviewed. Women and their partners were given the opportunity to make an

informed choice regarding the disposal of any pregnancy remains. We saw women were offered cremation or burial for the pregnancy remains, and that cremation ashes would be scattered in the remembrance garden if women did not wish to make alternative arrangements. All these options were talked through with the woman by the bereavement midwife.
- A varied menu was offered, including vegan and allergy specific foods. We observed partners being offered hot drinks on arrival in the antenatal ward.
- There were guidelines in place for following up women who did not attend antenatal care appointments.
- There was a pathway in place covering multiple pregnancies, the woman's antenatal management and the need for consultant led care. It also ensured that women with multiple pregnancies had an individualised care plan, including appointments with the multidisciplinary team as necessary.

Learning from complaints and concerns

- Patients knew how to make a complaint or raise concerns and were confident to speak up if needed. All patients we spoke with told us they had no cause to complain, but would feel able to do so if necessary.
- We saw posters on the walls noting the contact details of the patient advice and liaison service (PALS) in the antenatal outpatient clinic. We also saw complaints leaflets displayed in the antenatal and postnatal wards which contained the details of PALS, the independent complaints and advocacy service, the Parliamentary and Health Service Ombudsmen and the Care Quality Commission.
- Between August 2015 and August 2016 there were 43 complaints about maternity and gynaecology at WRH. The hospital took on average 55 days to investigate and close the complaints. This was not in line with their complaints policy, which stated that 90% of complaints should be closed within 25 days. However, from June to November 2016 the service achieved 100% compliance in responding to complaints within the deadline, better than the trust target of 90%.
- The service had introduced an openness letter. This letter was sent to patients when they had complained or there had been an incident involving them where it was not thought that harm had occurred and therefore the duty of candour had not been established. It explained to patients the process for investigating their concern and asked them what aspects of their care they would like to be reviewed. This was then incorporated into the terms of reference for the investigation.
- Lessons learned from concerns and complaints were shared during team meetings and in the weekly electronic newsletter. We saw examples of changes to practice as a result of complaints, such as extended the visiting hours on the antenatal ward for friends and family.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Although there was a vision to expand gynaecology services and obtain a dedicated ward there was no strategy in place to achieve this.
- Not all of the risks that we identified on the inspection, such as gynaecology patients being nursed in other wards or staying overnight in the outpatient gynaecology assessment unit, were recorded on the risk register.
- Staff sickness rates were above the trust's target.

However:

- The service had received positive feedback about its training and mentoring of student midwives.
- Staff were aware of the hospital wide values and vision to expand and create a second obstetric theatre and second bereavement suite.
- Local leadership were well established and approachable.

Leadership of service

- Local leaders were established and respected by their staff. We observed positive interactions between ward managers and staff of all levels and saw good working relationships had formed.
- The divisional director of nursing and midwifery was an interim position, due to leave in June 2017. The director was well liked by staff and staff told us they were more visible and approachable than their predecessors.

- An obstetric and gynaecologist consultant had taken on the interim clinical director role for women's services (maternity and gynaecology) two weeks prior to our inspection. As a result of this new position they had reduced their clinical obligations by one session.
- All leaders we spoke with were passionate about their service and keen to drive improvement.
- We saw posters up in the antenatal clinic with photographs of the senior leads of the service to ensure staff and patients were familiar with them by sight.
- At the time of our inspection the service did not have a non-executive clinical lead at board level due to a recent vacancy. Recruitment arrangements were in place to fill the position.

Vision and strategy for this service

- The service had a clear set of values, named 'PRIDE' which stood for patients, respect, innovation, dependable and empowerment. Staff we spoke with were familiar with the acronym and were able to provide most of the values.
- The maternity service also had a clear vision for what they wished to achieve in the coming years. All staff we spoke with were aware of plans to build a second bereavement suite and a second obstetric theatre. Charitable funds were being sourced to pay for the bereavement suite, however, staff were unsure how the obstetric theatre was to be funded and did not know a timescale for completion.
- The gynaecology service had a vision to provide a dedicated gynaecology ward, however, we were told this would be approximately two to three years in the future and staff were unsure about the certainty of this happening. This was linked into the trust wide future plans with the Future of Acute Hospital Services in Worcestershire.
- The values were developed following the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 report and were developed to be aligned with the NHS Constitution (a document that sets out of the objectives of the NHS and the principles to oversee the service). The vision for the expansion of the maternity service was due to increased demand on the bereavement suite and obstetric theatres. Following the centralisation of maternity inpatient services at the hospital, women were seen after pregnancy loss from 16 weeks, whereas previously they had only seen women over 20 weeks. As a result more women were being cared for following pregnancy loss and therefore there was a high demand for the bereavement suite. The vision for gynaecology was to develop a dedicated ward. The previous ward was lost in November 2015 due to the expansion of the antenatal ward facilities at the hospital. Staff in the department were eager to get a dedicated ward to enhance the care provided to women and improve efficiency.
- The sustainability and transformation programme (STP) plan focused on initiatives to develop maternity and gynaecology up to 2020. The plan directed women to access care in their locality, increasing the normalisation of childbirth and reducing interventions. In addition, the gynaecology pathways had been revised to provide more investigations within the primary care setting.
- We reviewed the service's plan, which incorporated their response to the previous CQC inspection, the future of acute hospital services review and the STP. This outlined the service's priorities in investing in staff by ensuring annual appraisals and appropriate training, achieving the 18 week referral to treatment time for gynaecology and achieving the 27% caesarean rate. Plans had been put into place to ensure that draft reports for serious incidents were completed within four weeks and that 100% of initial case reviews had been completed within 72 hours. In addition, the plan stated that fewer than 60 incident reports should be open electronic reporting system. Some of these objectives had already been achieved, notably the caesarean section rate and the number of open electronic incident reports.

Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services. Maternity clinical governance meetings were held monthly. We reviewed three sets of minutes; from May, June and July 2016. The minutes showed that clinical issues for example, neonatal checks and blood reports, updates from Public Health England regarding antenatal vaccinations and new patient safety alerts were discussed. Recent serious incidents were also discussed, with a focus on the duty of candour. There was evidence that performance indicators, for example, the rates of third and fourth degree tears were also discussed, so that the service knew their performance in these areas.
- Gynaecological clinical governance meetings were also held monthly. We reviewed one set of minutes from

June 2016. This covered new guidelines for post-menopausal bleeding, a review of overdue electronic incident reports, recent complaints and a review of the risk register.

- Maternity ward meetings were held monthly. We reviewed three sets of minutes; from April, May and August 2016. Incidents were reviewed with missed opportunities and lessons learnt identified. These meetings also reviewed the patient care improvement plan and infection control issues and actions were identified.
- Staff we spoke with were clear about their roles and understood what they were accountable for. Staff felt confident in escalating concerns and had clear lines of accountability.
- All risks on the risk register had review dates and almost all had evidence of progress. However, not all risks that we identified, for example, gynaecology patients being nursed on general wards and not being cared for by gynaecology specialist nurses were on the risk register. The risk regarding gynaecology patients staying overnight in the outpatient gynaecology assessment unit was also not on the risk register provided.
- There was a holistic understanding of performance, which integrated patients' experiences with safety, quality, activity and financial information. All staff we spoke with emphasised the importance of the patient experience and maintaining safety. Staff were also aware of the financial pressures on the service and how future development of service was dependent on accessing the required funds.
- There was a programme of clinical and internal audits which were used to monitor quality. These included national audits such as the National Neonatal Audit and internal performance indicators such as percentage of women smoking at delivery, number of third and fourth degree tears and the number of vaginal births after caesarean section. However, there was no audit of effectiveness in termination of pregnancies. Therefore, there were some areas where the service did not have access to information regarding performance and therefore risks in these areas could not be identified.
- There was an action plan in place to reduce the number of third and fourth degree tears, which focused on rolling audits, and providing training on minimising tears. However, the action plan provided was dated January 2015 and actions were marked as completed in March 2015. However, as the high incidence of tears noted were from April 2015 and March 2016 there was no evidence that this action plan improved practice
- There was an alignment between the recorded risks and what staff said was 'on their worry list'. Senior leaders told us that their main worries related to middle grade staffing levels, the lack of security tags for babies and the gynaecology referral to treatment times. All three of these were on the service's risk register and actions were in place to try to mitigate them.

Culture within the service

- There was a generally positive culture within the service. Due to the centralisation of maternity inpatient services in November 2015 some staff that had previously been based at other locations had been moved to the main site. Staff told us this had caused some problems when this had first happened and some members of staff had left, but all staff members were now well integrated with each other.
- The culture of the service was centred on the needs and experiences of patients. All staff members displayed enthusiasm for their job and put patients first.
- The culture encouraged candour, openness and honesty. Staff felt confident in raising any concerns and worked hard to ensure that patients were kept safe.
- There were arrangements in place to promote the safety and wellbeing of staff. For midwives involved in caring for any bereavement patients arrangements were in place for them to access counselling through occupational health if they required this.
- From July 2015 to July 2016 the service had 6% staff sickness rates, above the target of 4%.

Public engagement

- Patients' views and experiences were gathered through the Friends and Family Test. The results from these were very positive.
- Feedback was also gathered through thank you cards, which we saw displayed in ward areas, and the guest book in the Meadow birth centre.
- The service held a maternity service forum, which was ran by a member of the public. The forum worked with the divisional director of nursing and midwifery to support fathers to stay in the postnatal ward following the birth of their child.

- ‘Listening in action’ groups had been recently introduced, whereby senior managers listened to concerns from staff and the public. We were told of one gynaecology patient who had been very influential with the project and improved the environment of the gynaecology assessment unit as a result of her experience in the department.

Staff engagement

- Staff reported previously feeling disengaged and that their views were not reflected in the planning and delivery of services. This was particularly in regards to centralisation, where staff told us that they were not consulted and had only been given five days’ notice that services were going to be changed. However, this had been improved with the introduction of ‘listening in action’ groups whereby staff told the senior management team what they would like for their service. This had helped lead to plans for a second obstetric theatre which staff were pleased about.

Innovation, improvement and sustainability

- The service was rated as ‘outstanding’ by the Nursing and Midwifery Council for its mentorship and training in April 2016.
- The Meadow birth centre was also nominated as student experience of the year by the local university.

Services for children and young people

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

Information about the service

Services for children and young people at the Worcestershire Royal Hospital (WRH) provides outpatient and inpatient facilities as well as emergency and elective surgery for babies and children up to the age of 18.

The hospital opened in 2002 and provides paediatric services on a paediatric ward which has 35 beds or cots, and a neonatal unit comprising of 18 cots. Inpatient services at one of the trust's other locations closed in September 2016; activity and staff have all transferred to the WRH.

The paediatric ward comprises an assessment area with three beds and space for up to three seated patients. There are six single en-suite rooms, three of which are equipped for patients who require high dependency care. There is an adolescent area with two twin rooms and one single room, eight cubicles for babies and a four bedded bay for babies and children over six months of age. This area along with a further eight bedded bay is used predominantly for patients admitted for day case surgery.

Children aged 16 and over have the option of being treated on an adult ward if preferred.

The neonatal service is a level 2 unit and has two cots for babies who require intensive care. Four cots can be used for babies who require high dependency care, two of which can be flexed up to provide intensive care. There are a further 12 cots for babies who require special care.

Due to a lack of specialist doctors inpatient children's beds were centralised at Worcestershire Royal Hospital from 7 September 2016. The Alexandra Hospital was closed to admissions and paediatric staff moved to Worcestershire Royal Hospital. No changes were made to outpatient services for paediatric patients at the Alexandra Hospital

During the inspection we spoke with staff including medical and nursing staff as well as support assistants and play therapists. We also spoke with patients and their relatives or visitors. We made observations during the inspection and reviewed a range of documents both during and after the inspection.

Children and young people's services provided by this trust were located on three hospital sites, the others being Alexandra Hospital and Kidderminster Hospital and Treatment Centre, these are reported on in a separate report. However, services at each hospital site were run by one management team. Therefore, they were regarded within and reported upon by the trust as one service, with many of the staff working at all of the three sites. For this reason it is inevitable there is some duplication contained in the three reports.

Services for children and young people

Summary of findings

We rated services for children and young people as inadequate for safety and well-led, requires improvement for effective and responsive and good for caring, with an overall rating of inadequate because:

- Incidents were not always categorised correctly and lessons learnt not shared consistently.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning. Mortality and morbidity meetings for paediatrics were not discussed at any other meeting.
- Infection control policies were not consistently followed when caring for patients with an infection.
- Emergency medicines were not stored in tamper evident trolleys or boxes.
- A ligature audit had not been undertaken.
- Medicines had been reported missing; the investigation was not completed promptly to determine whether these had been stolen or had been an administrative error.
- Risk assessments had not been consistently completed for all patients and a standard template was not used to document risk for patients with mental health needs.
- Safeguarding checks were not consistently undertaken.
- Staff had not all completed the required level of safeguarding training.
- The trust had not established training in identification of female genital mutilation.
- Safeguarding policies were not complete and some had not been developed.
- The women's and children's directorate had not achieved their mandatory training target.
- Not all new-born babies were electronically tagged for security purposes.
- Staff were unclear what action they would take if a young person went missing.
- Assessments for patients who may have required 1:1 care from a mental health nurse were not always undertaken and 1:1 care was not consistently provided by a member of staff with appropriate training. We raised this with the trust who took action to improve the forms and monitor and report on the provision of care.
- Some shifts were understaffed.
- Clinical audits were not completed on a timely basis and the audit plan did not include local priorities.
- Some guidelines were out of date.
- The action plan to improve outcomes for patients with diabetes lacked detail.
- There were no formal supervision arrangements in place for nursing staff.
- Competency assessments were not up to date.
- Some staff had limited understanding of consent and mental capacity
- There were minimal psychology services available to patients and their families or carers.
- The needs of local people had not been considered as part of the annual business planning cycle.
- The department became busy at times and activity had increased since the reconfiguration in September 2016. The escalation policy had been followed but it was unclear how the increase in demand would be managed if the increase did not subside.
- Personal information for children with long term complex care needs, lacked detail or had not been completed.
- There was a lack of planning with regards to increased activity.
- There was a vision and divisional plan in place; however, this was not supported by clear objectives or actions.
- The governance framework was not effective. There was a lack of information flow between committees and meeting minutes lacked detail around the content of information presented.
- The risk register had failed to incorporate significant risks.
- The response rate for the friends and family survey was lower than the England average and people were less likely to recommend the service.
- Feedback about the service was not consistently acted on.

However, we also found that:

- Medications were stored securely and administered as prescribed.
- Patient records were stored securely.
- Access to the unit was secure.

Services for children and young people

- Clinical audits were detailed and supported by action plans.
- Patients' pain was assessed and managed effectively which was an improvement since the July 2015 inspection.
- Patients had their nutritional and hydration needs met.
- Action plans had been developed to improve patient outcomes.
- There were good multidisciplinary working arrangements in place.
- Patients care and treatment was planned and shared with other services as necessary.
- There were seven day services in place with some reduced out of hours.
- Staff interactions with patients were positive and patients were treated with dignity and respect.
- Patients told us that staff were helpful and that they explained things to them in a manner patients could understand.
- Patients and parents said they could be involved in care and treatment.
- Responses to the Care Quality Commission's 2014 children's and young people's survey were largely similar to or better than other hospitals.
- Most parents or carers would recommend the service to their friends and family, although the percentage who would recommend was lower than the England average.
- There was a play specialist who provided additional support for children on the paediatric ward during admission.
- The care needs of individuals had been considered.
- There were arrangements in place for managing complaints.
- Staff felt well supported by management at a local level.
- Care provided was patient focussed.
- Feedback about the service was gathered.

Are services for children and young people safe?

Inadequate

We rated services for children and young people as inadequate for being safe because:

- Incidents were not always categorised correctly and lessons learned not shared consistently.
- Perinatal mortality and morbidity meetings were not minuted, and there was little evidence of learning.
- Mortality and morbidity meetings for paediatrics were not held or discussed at any other meeting.
- Infection control policies were not consistently followed when caring for patients with an infection.
- Emergency medicines were not stored in tamper evident trolleys or boxes.
- A ligature audit had not been undertaken.
- Medicines had been reported missing; the investigation was not completed promptly to determine whether these had been stolen or were a result of an administrative error.
- Risk assessments had not been consistently completed for all patients and a standard template was not used to document risk for patients with mental health needs.
- Safeguarding checks were not consistently undertaken.
- Staff had not all completed the required level of safeguarding training.
- The trust had not established training for female genital mutilation.
- Safeguarding policies were not complete and some had not been developed, for example, management of celebrity visits.
- There was no clear policy on restraint and staff had not received training.
- The women's and children's directorate had not achieved their mandatory training target.
- Not all new-born babies were electronically tagged for security purposes.
- Staff were unclear what action they would take if a young person went missing.
- Assessments for patients' requirement of 1:1 care from a mental health nurse were not always undertaken and

1:1 care was not consistently provided by a member of staff with appropriate training. We raised this with the trust who took action to improve the forms and monitor and report on the provision of care.
- Some shifts were short staffed.

However:

- Medications were stored securely and administered as prescribed.
- Patient records were stored securely.
- Access to the unit was secure.

Incidents

- There were a total of 58 incidents reported within children and young people's services between the period 1September to 22 November 2016, with no incidents categorised as serious. During the previous inspection in July 2015, we identified concerns with regards to categorisation of incidents, delays and quality of investigations and poor sharing of lessons learned. We saw some improvement with regard to the management of incidents in the 2016 inspection, although more improvement was needed.
- The trust had developed an incident reporting policy which was available to staff on the trust intranet. Review of the policy confirmed it outlined the reporting process and responsibilities. During the July 2015 inspection we identified that the policy did not include guidance on categorisation of incidents. The policy was revised and subsequently approved in September 2016; definitions for categorisation had been included as an appendix.
- The trust used an electronic incident reporting tool to report and record incidents. The staff we spoke with were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so.
- Not all incidents required a formal investigation and most were updated with informal investigation details. During the 2015 inspection we found that there had been significant delays in investigating some incidents, with some taking up to five months. During the November 2016 inspection we observed that the length of time had reduced dramatically, but some still took longer than expected; 29% had taken between 20 and 60 days for an investigation to be completed with three still incomplete after four weeks.
- From the 58 incidents reported, all were categorised as low or very low harm with 12 (21%) not categorised, some of which dated back to October. The 2015 inspection identified that incidents were not always categorised to reflect the harm which could have or did occur. We found that improvements had not been made and that incidents were still not always categorised in accordance with policy, for example, one incident related to serious mental health concerns of one patient which could have caused at least temporary psychological harm; this had been categorised as low harm. Another incident which had been categorised as low harm which had the potential to have caused serious medical harm due the service not having staff on duty who were trained in a particular technique. This also had the potential to cause harm to future patients. We raised our concern with the trust who took immediate action.
- This meant that the incidents may not have been subject to the level of investigation required. Both incidents may have prolonged the patients' length of stay in hospital, which in accordance with policy may have met the requirements for minor or moderate harm.
- There had been one serious incident reported in the previous 12 months. The incident related to an outbreak of 'flu where both patients and staff had been affected. The incident was investigated and discussed at an ad-hoc meeting specifically established to review the series of events. An action plan was developed which included two actions, to increase staff participation in obtaining an influenza vaccination as well as educating parents on wearing personal protective equipment (PPE).
- Since the previous inspection incidents were discussed at the divisional weekly safety and risk review meeting. We saw that discussions were held regarding each incident and consideration was given to any immediate action required.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff understood the duty of candour regulation and told us that they would share information with patients and their parents or carers as soon as practicable

following an incident. Duty of candour in relation to the influenza outbreak was mentioned in the investigation report, and parents were informed verbally that their child had more than likely developed the virus whilst an inpatient. The report did not state whether this had been followed up in writing.

- Staff told us that learning from incidents was shared via a monthly newsletter. Newsletters included information on incidents which had happened and we saw an example of this in relation to the influenza outbreak. However, we noted that many of the staff we spoke with were unaware of any serious incidents which had taken place. We also noted that the action plan did not address issues around staff wearing PPE and we identified some concerns around this during our inspection.
- Patient safety alerts were received by the matron who cascaded these to staff via email.
- Perinatal mortality and morbidity reviews were held. However, these were not minuted and did not have attendees listed. The record of the meeting was completed as a case record. Whilst the trust told us these meetings were multidisciplinary, without a list of attendees we were unable to verify this. The trust told us there had been problems with case records being completed in a timely manner. The service provided us with two sets, from May and June 2016. We saw actions were identified in the June 2016 meeting, however, there were no timescales attached to these actions, nor a named owner. For the May 2016 meeting there were no identified actions for any of the cases discussed. This was not in accordance with the Royal College of Obstetricians and Gynaecologists (RCOG) improving patient safety guidance. We were told that a governance administrator had recently been appointed and that learning events would be formally recorded in the future.
- Paediatric mortality and morbidity meetings were not held. We were provided with a statement from the trust that, 'Paediatrics do not have a separate mortality and morbidity meeting, this is standing agenda item within the quality improvement meetings'. We reviewed the September and October quality improvement meetings for paediatrics, mortality and morbidity had not been listed as an agenda item or discussed. We noted in the October minutes it stated, that one of the consultant anaesthetists has requested that the division develop a process for monitoring morbidity cases.

Safety Thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre. Data was being collected nationally, providing a snapshot of patient harms on one specific day each month. This included data from the paediatric ward as well as the neonatal unit. It covered hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis, which are blood clots). From October 2015 to September 2016, the paediatric ward and neonatal unit had reported 100% harm-free care for the snapshot during this period.

Cleanliness, infection control and hygiene

- Good standards of cleanliness were maintained on the paediatric ward and neonatal intensive care unit (NICU) in accordance with trust policy; however, we noted that infection control policies were not consistently followed when caring for patients with an infection.
- We observed the paediatric ward, outpatients department and neonatal unit to be visibly clean during our inspection.
- Staff were required to complete infection control training as part of the mandatory training programme. 89% of staff who worked within the women and children's division had completed their infection control training against a target of 90%.
- We reviewed a sample of cleaning records and found these to have been completed on most days on each of the areas within paediatrics and the neonatal unit.
- We saw; "I am clean" stickers in use across all clinical areas stating the date and time of equipment was last cleaned, this showed that equipment was clean and ready for use.
- We saw that staff were 'arms bare below the elbows" and that hand gel was available throughout the ward areas.
- Isolation facilities were available on both the paediatric ward and neonatal unit to prevent the spread of infection. Signs to inform staff of the need for isolation procedures were visible.
- Compliance by staff with infection control guidance was inconsistent. We observed staff failing to adhere to the correct source isolation protocols for patients with

bronchiolitis. Staff left doors open when they should be have been closed, patient records were kept inside the patient's room and staff members sat in the patient's room without wearing the correct personal protective equipment (PPE).

- We were provided with infection control audits for the neonatal unit, paediatrics and children's clinic which demonstrated compliance rates in excess of 95% with exception of the July 2016 audit on the paediatric ward; 86% compliance was achieved. Issues identified in the July audit included a dirty hand gel dispenser and the staff microwave oven was also dirty. A re-audit was undertaken in September 2016, compliance of 96% was achieved, although we noted the staff microwave still required cleaning.
- Hand hygiene audits demonstrated 100% compliance in September and October for the paediatric ward and close to 100% compliance for the neonatal unit in the same period, it was noted one member of staff on the neonatal unit was wearing false nails which the manager was requested to address.
- A patient environmental audit (PEAT) was undertaken in July 2016 in the children's clinic, the neonatal unit as well as the paediatric ward. A high rate of compliance was achieved for the clinic and neonatal unit at 95%; this was lower for the paediatric ward at 88%. Some specific issues were identified on the neonatal unit and paediatric ward in relation to cleanliness which included an unclean toilet seat on the neonatal unit as well as dirty beverage areas and low surface areas on the paediatric ward. Action plans had been developed which included deadlines for action and a named lead assigned for each issue identified.
- Clinical waste was appropriately stored and disposed of.

Environment and equipment

- The paediatric department including NICU had adequate equipment to meet the needs of children and young people. Equipment was maintained and most portable appliances had been subject to relevant safety tests. However, resuscitation equipment was not stored safely and a ligature audit had not been undertaken.
- The resuscitation equipment in the paediatric department, including NICU contained varied sizes of equipment to cater for the range in ages and sizes of the children. Daily checks were performed to ensure required equipment was available and that emergency medicines and hypoglycaemia medication (to treat low blood sugar) on the resuscitation trolley remained in date but were not in tamper evident trolleys or boxes.
- There was a dedicated area within the post-operative recovery room to care for paediatric patients.
- We reviewed a sample of equipment items in paediatrics and neonatal wards and found that equipment had been serviced and most items had been subject to relevant safety tests, however, we did find two items of equipment in the children's clinic which had not been tested.
- During the July 2015 inspection we found that the treatment room on the paediatric ward which contained a variety of equipment, including sharp items such as razor blades was not locked. We raised this with the trust during the previous inspection, locks had been fitted and were still in place in November 2016.
- The July patient environmental audit (PEAT) demonstrated a high rate of compliance for children and young people's services. Some specific issues were identified on the paediatric ward in relation to the safety of the environment including fire doors being left open and electrical equipment not being safety tested annually. During our inspection we saw that fire doors were kept closed and most of the equipment, but not all, had been subject to relevant safety testing.
- The paediatric ward had a ligature free room which could be used to care for patients with mental health needs. On occasions there was more than one patient with mental health needs on the ward. We were told that under these circumstances another side room would be used and potential ligature risks would be removed. A ligature risk assessment of the entire ward had not been undertaken which meant staff were unaware of potential risks posed to patients, particularly those with mental health needs.

Medicines

- There were arrangements in place for management of medicines which included their safe ordering, prescribing, dispensing, recording, handling and storage. However, incidents reported were not always reviewed by managers with mitigating controls put in place promptly.
- We saw that room and fridge temperatures were checked daily and that these had all been within the required range.

- We found that medicines were securely stored in both the paediatric ward and NICU.
- Controlled drugs were stored in accordance with required legislation. A controlled drug register was used to record details of controlled drugs received into the cupboard, administered to individual patients, as well as controlled drugs which had been disposed of. We reviewed a sample of controlled drugs and found that accurate records had been maintained.
- However, an incident had been reported in September 2016 in relation to medicines which could not be accounted for. The investigation was in progress and at the time of inspection it had not been established whether this was an administrative error, or if the drugs had gone missing.
- Medication records were completed for patients. A medicine administration record specific for children was used to record medication prescribed and administered and we saw that these had been completed appropriately for patient files we reviewed. Each patient had their weight checked and medicines prescribed accordingly.
- If patients were allergic to any medicines this was recorded on their prescription chart.
- The paediatric ward and NICU had a dedicated pharmacist who came to the ward Monday to Friday. Checks were made on stock levels as well as audits of the controlled drugs registers; pharmacists also undertook checks on patient medication records.
- Between 1 September to 21 November 2016, 13 medication incidents had been reported. Five of the incidents had not been categorised and eight categorised as very low harm. Most of the incidents had immediate and subsequent actions that had been taken recorded. Two of the incidents had occurred approximately four weeks earlier but had not been subject to a management review, even though the implications had the potential to be serious because one of these incidents a child had been sent home with another patient's medication.

Records

- Records were accurate complete, legible, up to date and stored securely.
- During the July2015 inspection we observed that a whiteboard was used which displayed the full name of all patients currently on the ward and that this was in full view of all patients and relatives who entered the ward. During the November 2016 inspection we found that this had improved and identifiable patient information was not recorded on whiteboards displayed in areas which patients or visitors could see.
- We found patient records were locked securely in trolleys located at the nurses' stations. This had improved since the 2015 inspection, when records were not securely stored.
- We reviewed a sample of patient records, for medical and surgical inpatients as well as outpatients and those attending day surgery. The records we reviewed were up to date and contained appropriate information.
- There were flags on the system to identify vulnerable patients. For example, patients on the child protection register.
- We reviewed a sample of advance care plans for a sample of patients and saw that these had been completed and reviewed. Do not attempt cardio pulmonary resuscitation (DNACPR) sections of the plan had been completed and signed by all appropriate parties.

Safeguarding

- Since the July 2015 inspection some action had been taken with regards to safeguarding, but other concerns remained. During the current inspection we found that there were systems in place for safeguarding concerns to be identified and reported, however these were not consistently followed. There were improvements in the completion rate of relevant training but policies had not been updated, which we had identified in 2015.
- It was identified in the 2015 inspection that the safeguarding children policy did not include a section on the process to follow in deciding whether or not a safeguarding referral was necessary when a patient or their parent self-discharged before the patient was deemed medically fit. The policy had been updated in 2016, however, the in the revised version self-discharge not been considered. During the November 2016 inspection we reviewed some case files and found that one patient with mental health needs had self-discharged and had not been seen by a doctor prior to leaving the ward. If there is no policy on self-discharge and correct protocols are not followed this may have placed the patient at risk if they leave hospital before they are medically fit to do so. In addition this could be an indicator of safeguarding concerns.

- We also noted that there were some policies which had not been developed, for example, allegations and safeguarding supervision.
- There are four levels of safeguarding children training, levels 1, 2, 3 and 4. The Intercollegiate Document, Safeguarding Children and Young People: roles and competences for health care staff 2014 states that, 'all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns must be trained to level 3'. Named professionals must be trained to level 4. There is an expectation that level 3 training is multi-agency and will include scenario-based discussions. The trust currently only offer on-line training which does not conform to the recommendations from the intercollegiate document.
- Compliance with completion of adult safeguarding training for the women and children's division was positive with 97% of staff having completed the training against a 90% target. Compliance was very low for children's safeguarding at all levels and across all staff groups. Data provided to us by the trust mid-November 2016 reported that 69% of all eligible staff groups working within paediatrics had completed level 3 children safeguarding training, medical staff had achieved compliance of only 41% compared to nursing staff who had achieved 79%; this was significantly lower for medical and nursing staff who worked in adult outpatients / surgery but treated children at 15% and 6% respectively. Compliance with safeguarding children level 2 was also low and for all staff groups this was 43%.
- We also noted that non-paediatric staff who may have come into contact with children, had not completed safeguarding training to the required level, staff who worked in adult outpatients who may have seen children within their clinic, for example, ear, nose and throat (ENT) or surgery who may have children on their list had not completed level 3 training.
- The staff we spoke with all had a good understanding of how to recognise safeguarding concerns and confidently talked about example scenarios as well as the reporting process. However most of the staff we spoke with were less familiar with what they would do if there was a case of female genital mutilation (FGM) or child sexual exploitation (CSE). Most of the nursing and medical staff told us they would refer to guidance or to their manager and some said they did not recall having received training on these specific elements of child protection. The trust had not yet established a training course on FGM as indicated from our inspection in 2015; external courses could be accessed by trust staff, although the staff we spoke with were not aware of this.
- We reviewed a sample of patient records and found that relevant safeguarding checks and/or referrals had not consistently been made.
- During our inspection there were two children on the wards who were subject to child protection proceedings; it was required that records were maintained of visits and contact from their parents. We observed that whilst these had mostly been completed, there were gaps in records when visits had taken place.
- There had been no serious case reviews since the previous inspection.

Mandatory training

- There was a structured induction and mandatory training programme. However, the trust's mandatory training target of 90% had not been achieved although there had been some improvement in the completion rate since the July 2015 inspection.
- There were 12 mandatory training modules which each member of staff was required to complete in line with agreed frequency, this included; equality and diversity including bullying and harassment, medicines management, conflict resolution, health and safety, information governance, fire, moving and handling, safeguarding adults, safeguarding children, resuscitation, hand hygiene and infection control.
- The staff we spoke with told us that they had completed their mandatory training. Staff were allocated dedicated time to complete 'face to face' mandatory training, such as basic life support. Some of the mandatory training was completed on line and it was expected that staff completed this whilst working on the ward during quieter periods. The staff we spoke with told us that this did not pose any difficulties and that they found training provided by the trust helpful.
- Overall, for all staff groups within the women and children's division there was a compliance rate of 64% for all mandatory training courses. This did not meet the trust target of 90%. The was variable attendance across training sessions. For example, 0% of additional professional and technical staff had completed conflict resolution and equality and diversity. However,

compliance with fire safety and infection control was 100% for this same group. Medical and nursing staff had a low level of compliance with medicines management, at 33% and 30% respectively. Higher attendance rates had been achieved for some other courses, for example 87% of medical staff had attended manual handling training and 85% of nurses had completed information governance. 84% and 87% of medical and nursing staff had completed basic paediatric life support (BPLS).

- The percentage of staff trained in paediatric intermediate life support (PILS) and/or European paediatric life support (EPLS) training had improved since the previous inspection. We confirmed that 91% of staff had completed their PILS training which was similar to last year, 68% of nursing staff had completed EPLS compared to 48% from the previous year and 52% of nursing staff who worked on NICU had completed the NLS, this included 89% of nurses who were qualified in speciality. There were always a minimum of two nurses qualified in resuscitation on each shift.

Security

- Security arrangements were in place, but staff were unclear what to do if a baby, child or young person went missing. Baby tagging arrangements were in place, however, the trust were in the process of changing suppliers which had resulted in a shortage of tags. We were told that babies who were assessed as 'higher risk' of abduction because of known concerns were tagged. This had been risk assessed and women informed that there were insufficient tags and asked them to not leave their baby unattended.
- There was a buzzer entry system for both the neonatal ward and paediatric ward and we observed staff asking visitors who they were visiting before entering. Exit from the paediatric ward and neonatal unit was also controlled and required a member of staff to release the door for patients and visitors prior to leaving the ward or unit.
- The safeguarding policy included a section on abduction of/missing babies/children. This included action cards of procedures to follow in the event of a missing/abducted baby or child. Staff were expected to report concerns to the person in charge immediately who would telephone 2222 (emergency number), explain the circumstances and subsequently 'lock down' the department. The member of staff working on switchboard was responsible for reporting this to the police whilst staff on the ward searched the area. The action cards did not indicate whether the hospital security staff should be contacted, or what staff should do if they were immediately unable to locate the person in charge. We asked staff what they would do if they became aware of abduction or missing child, each member of staff we spoke with provided a different account of action they would take and therefore were unfamiliar with the trust policy. This meat that if a baby or child went missing, immediate action may have been delayed.
- Staff who worked within paediatrics had not undertaken training on restraint or supportive holding. The trust did not have a single policy on restraint or supportive holding, although there were some pathways. The pathways provided an overview of documentation to be completed and issues to consider but were unclear on whether restraint could be used or not or under which circumstances. The main focus of the pathways were around supportive holding for younger children. The staff we spoke with were uncertain what to do if a situation arose which required a patient to be restrained or held.
- The Royal College of Nursing (RCN) guidance on, "Restraining, holding still and confining children and young people" states that, "Restraint of children within health care settings may be required to prevent significant and greater harm to the child themselves, practitioners or others. For example in situations where the use of de-escalation techniques have been unsuccessful for children/young people under the influence of drugs or alcohol and who are violent and aggressive. If 'restraint' is required the degree of force should be confined to that necessary to hold the child or young person whilst minimising injury to all involved". The policy also says, "Greater emphasis needs to be placed upon enabling nurses to acquire knowledge and skills through the provision of locally based training programmes". It also recommends that an organisation risk assessment is undertaken to determine training needs and techniques required for each area. The guidance states that, "Training provision should be differentiated between restraint and holding still for clinical procedures, and targeted at relevant groups of nurses. For example, nurses working in areas such as the emergency department, walk-in centres and GP practices should receive training in using restraint, as well as holding still for clinical procedures".

Services for children and young people

Assessing and responding to patient risk

- Risks to patients were not always recorded or managed appropriately, particularly patients with mental health needs.
- The paediatric ward had one bed which they used to care for patients who had 'higher dependency needs' although the service was not commissioned to provide high dependency level two care. We noted there was no set criteria for which patients should be admitted to the higher dependency room. There was no policy on care management of patients within this room
- We were informed by the trust that they were monitoring the number of patients and their clinical conditions treated in the higher dependency bed, to establish whether funding should be applied for to expand the service to provide level two care. We were provided with a list of patients treated within the higher dependency room and their clinical conditions. The information provided did not state the patient's acuity or dependency and therefore, it was not possible to establish what level of care was required.
- There were no intensive care unit (ICU) beds. Patients who required ICU level care were stabilised in the adult ICU and transferred to a suitable tertiary centre. There were no paediatric patients admitted to an ICU bed during our inspection, however, we were told that if a patient was admitted a children's nurse would be requested from the paediatric ward.
- Theatres had the capacity to run three emergency lists and would stop routine surgery to divert resources as required.
- The NICU had two intensive care cots and four HDU cots, two of which could also be flexed to ICU making a total of up to four ICU cots. There was set criteria for which babies should be admitted to each cot.
- A paediatric early warning score (PEWS) tool was used to monitor and manage deteriorating patients on the paediatric ward. A separate tool was used according to the child's age and we saw examples of these having been completed. Each patient's PEWS score was calculated on admission and subsequently at the agreed frequency in accordance with their latest score. We reviewed a sample of patient records and found that the PEWS tool had been completed although the frequency of observations had not been documented in all cases; but action had been taken as required. We noted however that a separate sepsis bundle was not used. Sepsis 6 (a bundle of medical therapies used to reduce the mortality of patients with sepsis.) had been incorporated into the PEWS tool. Sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition triggered by an infection of injury. Although staff recognised the signs of potential sepsis and understood the correct course of action, in absence of a separate sepsis tool there is an increased risk that appropriate action may not be taken or in time.
- We reviewed the findings from the November 2016 monthly PEWS audit. The audit results demonstrated that 100% of patients had a PEWS chart with 80% of those with a score of higher than 3 having been escalated which meant that 20% were not. We requested a copy of the action plan developed to address this but it was not provided. Therefore there was a risk that actions may not have been implemented which could have compromised patient safety. We raised completion of PEWS charts with the trust that provided us with evidence of 100% compliance in December 2016 and on the ward in January 2016, however, one child had not had their PEWS scores completed whilst in theatre. The trust informed us of action they had taken to address this.
- The NICU did not use a new-born early warning trigger and track (NEWTT) tool to monitor and manage deteriorating patients. Observations of vital signs were recorded to monitor any potential deterioration. However, by not using a nationally recognised tool, increased the risk that the deterioration of a new-born baby may not have been recognised and/or escalated as promptly as it could have been.
- Patients who were admitted to the paediatric ward because they had 'self-harmed', taken an overdose or had suicidal intent were admitted to an anti-ligature side-room if available to ensure they were cared for in a safe environment. If the room was in use by another patient, a separate side-room would have been used and ligature risks would be removed as far as possible. This had been recorded on the division's risk register. Patients were also observed every 30 minutes whilst awaiting assessment from a mental health specialist from the child and adolescent mental health services (CAMHS) team. However, an initial assessment could take a number of hours depending on the time of day the patient was admitted. CAMHS were available Monday to Friday 9am to 5pm. An adult mental health crisis team provided some cover out of hours.

- Most of the staff we spoke with told us that specialist support from a registered mental health nurse could be requested, but that these requests were not made consistently and that on occasions reliance was placed on ward staff as well as parents and carers to provide 1:1 care. This was supported through our observations as well as our review of patient records and incident reports. We found that most patients were not routinely assessed to determine whether 1:1 care was required, an assessment form was in place but this did not include a section to complete information. We found that information about a patient's mental health needs, when recorded was written in the nursing notes. A risk assessment was used in the emergency department (ED) to assess a patient's needs. However, the risk assessment was an adult mental health triage assessment form and therefore not appropriate for children. There was also nowhere on the assessment to record the assessed level of risk either by way of recording comments or a tick sheet. Therefore staff either had to write in the margins or record information in the patient's nursing notes. A joint assessment form was used by the paediatric ward to record assessments, although this was used inconsistently and information was frequently recorded in the nursing notes. An assessment of 1:1 care needs was not routinely made until the CAMHS team arrived. We saw some examples where 1:1 care was not requested until the patient's behaviour had deteriorated or became disruptive. Review of incidents reported by paediatric nursing staff further supported our findings.
- We raised concerns with the trust around the use of risk assessments as well as 1:1 care. The trust provided a statement and evidence that the assessment form had been adjusted with the revised form circulated for use in January 2017. The trust also informed us that in the future, the Matron would report on completion of the form as well as the RMN cover provided to divisional governance meetings (monthly meeting).
- The paediatric ward had three side rooms which they used to care for patients who had 'higher dependency needs' although the service was not commissioned to provide high dependency level 2 care. One of the rooms doubled as an anti-ligature room as required.

Nursing staffing

- Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift. However, some shifts were not fully staffed compared to the number planned and in accordance with national guidance.
- In September 2016 the trust reported a 9.36% vacancy rate on the paediatric ward, 9.60% for the neonatal unit and 2.89% for the paediatric clinic. Paediatrics and the neonatal unit used their own nurses to work on the bank to cover shifts and promote continuity of care; no agency staff were used
- Paediatric nursing staff sickness rates for April 2015 to March 2016 was 4.59% on the paediatric ward, 4.83% on the neonatal unit and 2.79% for the paediatric clinic. This was better than the trust target of 5%.
- There were an agreed number of nurses working each shift (nine during the day and six at night on the paediatric ward), there was no increase in staff for winter pressures in particular due to the increased number of respiratory related illnesses during this time. There were two support assistants planned during the day and one at night. This meant that the ratio of 70:30 registered to unregistered staff recommended by the Royal College of Nursing was not met. The trust did not have any plans in place to address this and it had not been identified as a risk.
- We reviewed 15 shifts during the first week in November on the paediatric nursing rota. We found that most shifts were below the planned number during the day but there were always six nurses at night. Nine of the 15 day shifts were short according to the plan however they largely met the RCN safer staffing guidance according to age of the child. The RCN guidance recommends a ratio of one nurse to three patients for under two year olds and one to four for children aged over two. Three of the 15 shifts were short by more than one whole time equivalent (WTE) and a further five shifts were short by less than one whole time equivalent. Seven shifts had the required number according to age related occupancy and RCN guidance.
- All nurses who worked on the paediatric ward were registered nurses (child branch) and each shift had a minimum of one nurse trained in European paediatric life support.
- The NICU planned for five nurses during the day and at night with support from up to two nursery nurses. We reviewed a sample of ten whole shifts and found that 50% of these were short of either nurses or nursery

nurses according to the British Association of Perinatal Medicine guidance. This ranged from one WTE to two WTE. The NICU worked to national requirements to provide care at 1:1 for ICU cots, 1:2 HDU cots and 1:4 NICU. There had been no staffing shortages reported as incidents for the period we reviewed since September 2016.

- Most of the paediatric and NICU nursing staff we spoke with told us that staffing arrangements had improved since the reconfiguration and worked well, but that on occasions the ward could become busy particularly when patients with high acuity or dependency were admitted. Staff told us that sometimes this meant they did not get time for a break but that patients were cared for safely. Efforts were made to bring in additional staff, but this was not always possible.
- We were told by staff who worked in the children's clinic that this was safely staffed and well managed. We observed interaction between staff and those patients attending the clinic, there were sufficient nurses and the clinic slots were appropriate for the number and complexity of patients.
- We observed nursing handovers on NICU and the paediatric ward. They were detailed and effective, with each patient on the unit/ward discussed by the nurse in charge and allocated to a nurse for the shift.

Medical staffing

- Staffing levels and skill mix were planned so that patients received safe care and treatment, although consultant coverage of the assessment area did not always work as anticipated.
- There was a designated consultant for the paediatric ward, Monday to Friday, 8.30am to 5pm, Saturday and Sunday 9am to 3pm; consultant of the week (COW). A second consultant was available on the paediatric ward and provided cover for the assessment area as well as the emergency department as required until 10pm Monday to Friday. There was an allocated consultant for neonatal care, Monday to Friday 8.30am to 5pm and at weekends from 9am until 3pm. Out of hours consultant cover was provided on an on-call basis. This was an improvement from our previous inspection, when we reported that consultant cover was not provided in the evenings. We were told that "facing the future" guidance with regards to medical staffing was largely met, although there was not enough consultant presence at the weekend to meet the target that all patients were seen by a consultant within 14 hours of admission.
- There was a resident middle grade doctor present 24 hours per day and each shift had three middle grades, although there was a vacant post which should have been filled by the deanery but was vacant at the time of our inspection. There were four additional trainees during the day and two out of hours.
- We were told that the department could become busy at times, but that it was managed safely. Due to the challenges in filling vacant junior doctor posts advanced nurse practitioners were being trained.
- Consultants in the assessment area provided advice to GPs as to whether a child should attend for further review. We were told that this worked well when a consultant was present but that when they were not, it was the staffs' perception that this resulted in unnecessary attendances which could have resulted in a significant demand on resources.
- During our previous inspection in July 2015, there was a 22% vacancy rate for middle grade doctors and this had placed pressure on the unit. Improvements had been made since the reconfiguration of paediatric services and the vacancy rate for all medical staff was 9% in September 2016. We were told that there were two long term locum doctors to cover vacant middle grade positions.
- The staff we spoke with told us that the department felt very different to the previous year and that the reconfiguration had noticeably helped improve staffing arrangements.
- Handovers took place twice each day and were led by a consultant paediatrician. We saw that individual patients were discussed and that adequate information was shared.

Major incident awareness and training

- There were arrangements in place to respond to emergencies; however these had not been updated to take into account the recent reconfiguration of children's services.
- The trust had a major incident plan reviewed in June 2015, prior to the reconfiguration. The policy had been approved by the emergency preparedness, resilience

and responsive committee reporting to the trust board. However, it was unclear whether this had been updated. We asked the trust for further information, but this was not given to us.
- We were told by managers that they were unaware of a business continuity plan in place to deal with other adverse events, for example if there was a flood on one of the wards.
- There were bed management plans in place to deal with escalation issues for staffing shortages or high bed occupancy; however, these had not been revised since the reconfiguration had taken place. Mitigation plans therefore still included as a course of action to assess bed availability at the Alexandra Hospital which was no longer open.

Are services for children and young people effective?

Requires improvement

We rated services for children and young people as requires improvement for effective because:

- Some guidelines were out of date.
- Clinical audits were not completed on a timely basis and the audit plan did not include local priorities.
- The action plan to improve outcomes for patients with diabetes lacked detail.
- There were no formal supervision arrangements in place for nursing staff.
- Competency assessments were not up to date.
- Some staff had limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

However:

- Clinical audits were detailed and supported by action plans.
- Patients' pain was assessed and managed effectively which was an improvement since the July 2015 inspection.
- Patients had their nutritional and hydration needs met.
- Action plans had been developed to improve patient outcomes.
- There were good multidisciplinary working arrangements in place.
- Patients care and treatment was planned and shared with other services as necessary.
- There were seven day services in place with some reduced out of hours.

Evidence-based care and treatment

- Patient's care was mostly planned and delivered in line with evidence based guidance, however, procedures and guidance available to staff were not always up-to date.
- Audits were undertaken to monitor compliance. Planned clinical audits were not always completed on a timely basis and local priorities were not included.
- There were a range of trust wide policies as well as those specific to neonates and paediatrics. We reviewed a sample of policies and procedures and found that some of these were out of date, for example bed management and escalation policies as well as the policy on sepsis which did not refer to the latest National Institute for Health and Care Excellence (NICE) guidance. The neonatal nasogastric tube feeding for neonates was also out of date, last revised in 2011 and due for review in 2014.
- This was further supported by our review of patient records which demonstrated that patient care was provided based on new and out of date guidance. For example we saw that staff treated patients with bronchiolitis based on 2006 and 2013 guidance; the most up to date NICE guidelines were published in 2015. The department's quality improvement meeting (QIM) were responsible for reviewing and approving guidelines.
- We were provided with copies of the joint paediatric and neonatal clinical audit plans for 2015/16 and 2016/17. The audit plan was devised based on audits required nationally as well as to assess compliance with NICE with regards to paediatrics and local priorities.
- The audit plan for 2015/16 listed 19 audits which had been planned for the year, of which 12 had been completed; the action plans were incomplete for three of these. Two were abandoned and the remainder recorded as 'in progress', but there was no justification recorded as to the reason audits were delayed or discontinued.
- The 2016/17 plan listed 20 audits for the year, one had been completed with 14 in progress and the remainder not started, at the time of our inspection in November

2016. Both audit plans comprised only of national audits and compliance with NICE guidance. Therefore there was an overall lack of involvement in completing audits or drawing from incidents or other issues to inform the audit process.

- We requested copies of two completed audits; management of constipation in children and bronchiolitis management as well as the associated action plans. The audit reports clearly defined the aims and objectives along with a summary of findings and conclusion and were supported by action plans which focussed on improved learning.

Pain relief

- Assessments were made of patients' pain levels and arrangements made to ensure pain was managed effectively. This was an improvement on the 2015 inspection when we found completion of pain assessments was inconsistent.
- There was a pain protocol for babies which outlined how to identify, assess and manage pain experienced by babies using a nationally recognised tool for scoring pain in children. We saw these in use.
- Pain assessment charts were used by staff to help determine pain scores for babies and young children. Through review of patient notes we saw that pain assessments had been completed. Pain relief was prescribed and administered as appropriate when pain assessments had been completed.
- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.

Nutrition and hydration

- Patient's nutritional and hydration needs were met during their stay in hospital.
- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs to ensure well balanced meals were provided.
- Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- There was a hot meal each day; the choices included healthy options, as well as more traditional children's foods. The meals were designed to cater for a variety of ages. Meals were prepared in the main hospital kitchen.
- The patients and parents we spoke with told us they were satisfied with the food and drinks provided.
- Snacks were available on the paediatric ward 24 hours a day. These included fruit, toast and cereals. This meant that patients could have food at any time outside of meal times.
- Food to meet specialist dietary requirements was available on request including gluten free and low allergen. Meals were also available to meet patient's cultural and religious needs. Staff said they could order specific foods if required and there were no problems obtaining them. This showed a variety of nutritional needs were catered for adequately.
- Staff who worked on the neonatal intensive care unit (NICU) promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- On both units patients were weighed on admission and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support.
- Parents and carers visiting a child on the paediatric ward could also make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- Outcomes for patients' care and treatment was collected and monitored in line with national audit requirements. Intended outcomes for some patients were worse than the national average, the trust had developed action plans to make improvements, although the action plan to improve diabetes services lacked detail.
- The trust took part in the National Paediatric Diabetes Audit, April 2014 to March 2015 which showed that the percentage of patients with poorly controlled diabetes was higher than other trusts. The trust had developed an action plan in response to the audit which included four actions:
  - to employ more staff
  - offer additional dietetic appointments to families each year,
  - arrange for more opportunities for patients and families to meet with other families who also had diabetes
  - improve self-management through education.
- Each action was listed as completed but it was unclear what milestones there were or how actions would be or

were achieved. For example the action which stated; 'to employ more staff' there was no information about what staffing resources lacked and what was required or how this would be achieved.

- According to data sourced from Hospital Episode Statistics (HES), the multiple emergency admission rate for December 2014 to November 2015 for children with asthma and epilepsy was worse than the national average. An audit on epilepsy was last undertaken in 2014 and published on HES. An audit on asthma had been undertaken in 2015, however, this related to the Alexandra Hospital and not Worcestershire Royal. The 2016 audit was still in progress.
- The trust participated in the National Neonatal Audit Programme (NNAP) 2015. The most recent data collection in 2014 was reported on in 2015 and found that 80% of babies eligible for retinopathy screening (retinopathy is a disease of the retina which results in impairment or loss of vision) were screened against a target of 100%. The audit findings also reported 79% of babies admitted to NICU had a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission against a target of 100%. An action plan had been developed to address the weaknesses identified.

Competent staff

- Staff did not always have the right qualifications and experience to do their job. Most staff had received an appraisal and the trust's target of 85% had been met. There was no formal process in place for staff supervision and competency assessments were not up to date.
- There was a practice development nurse for neonatal nurses, but not paediatrics. Competency assessments and updates were clearly structured for nursing staff who worked on NICU.
- Competency assessments were in place for paediatric nursing staff, however, these were not regularly reviewed and the two different systems in place prior to the reconfiguration had not been merged. This meant that competencies for some staff were overdue or out of date, for example competency assessments on the use of continuous positive airway pressure (CPAP) (which is used to help patients breathe more easily) which were overdue for all records we reviewed. We raised this with the trust following the inspection; the trust provided us with a statement that as of 4 January 2017 70% of nursing staff were up to date with their CPAP training. The trust also informed us that the rota was monitored to ensure there was always a competent nurse on duty.
- Staff who worked on the paediatric ward had not received training in caring for patients with mental health needs. Patients with mental health needs were regularly admitted to the ward through the emergency care pathway, and although registered mental health nurses from a local agency could be requested, requests were not always made and reliance was placed on ward staff that had not been equipped with the necessary skills.
- Staff completed an annual appraisal as part of their personal development review. The staff we spoke with told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Review of data provided, confirmed that 94% of staff had received an appraisal which was compliant with the trust's target.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked. We confirmed through review that all staff listed as employed and registered had a valid registration.
- A total of 62% of nurses who worked on NICU had completed their post registration qualification in the speciality (QIS) neonatal care against the recommended standard of 70%. The trust had set an internal target of a minimum of two QIS nurses per shift and from review of a sample of rotas we saw that this had been met.
- The paediatric ward had two beds which were used for 'higher dependency patients', although these were not commissioned HDU beds.
- The Royal College of Nursing safer staffing guidance recommends that each ward/department has at least one qualified member of staff working each shift who has undertaken European Paediatric Life Support (EPLS) training. We reviewed a sample of rotas and confirmed this recommendation had been met for each of the shifts reviewed.
- The unit had access to advice from specialist tertiary centres as required.
- We saw from review of patient records that all children admitted with an acute medical problem were seen by a middle grade doctor within four hours of admission and within 14 hours seen by a consultant. Our review of

records confirmed compliance, however, it was not always possible to provide this level of cover, for example at weekends there were periods where a consultant was not present for up to 17 hours.
- From the records we reviewed all children with an acute medical problem had been assessed by a consultant prior to discharge.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients care and treatment.
- The staff we spoke with told us that there was good support for patients from other services, including physiotherapy, dietetics and speech and language therapy.
- We saw multidisciplinary team involvement in care was documented in children's notes.
- Play therapists were available on the ward six days per week. Play therapists provided communication between medical and nursing staff, and patients and their parents to ensure the child's needs were catered for during procedures. Play therapists also provided additional support in distraction for younger children whilst undergoing procedures and there was some support for the children's centre as well as adult outpatient areas where children attended appointments, for example ear, nose and throat (ENT) or the fracture clinic.
- A dedicated pharmacist came to each ward to check supplies and review drug charts for patients on the ward.
- Access to psychiatric services was available Monday to Friday from the local child and adolescent mental health service (CAMHS). This service was unavailable at weekends. Therefore if a child with mental health needs presented over the weekend, they were admitted and waited until Monday morning for a comprehensive assessment. There was some support from adult mental health teams.
- Staff who worked on the paediatric ward and neonatal unit regularly liaised with other external professionals including social services, health visitors as well as school nurses. We were told that there were positive working relationships between the different disciplines.
- The department did not have support from a psychologist except for patients diagnosed with diabetes. This meant that holistic care and review of patients with mental health needs did not take place.

Access to information

- Patients care and treatment was planned and shared with other services as necessary.
- Patient records were requested as needed on admission or in advance for outpatient appointments. We were not informed of any issues with access to records. Test results were obtained promptly from the relevant departments to ensure clinical decisions could be made based on supporting pathology or radiology results.
- Transition arrangements were in place for patients with diabetes who were approaching adulthood, which was supported by a policy and self-management plan for patients. The self-management plan included a competency checklist for the child making transition to adult services.
- The transition arrangements for other conditions were not clearly defined and therefore there was a risk that children may lack the support and skills required to take control over the management of their continuing care.
- A copy of the patient's discharge summary was given to the patient as well as sent to the patient's GP. The summary was scanned onto the system, hard copy notes were sent for destruction and notes subsequently accessed using the electronic patient record tool.
- Transfer, referral and discharge information was communicated effectively. Children's services used an electronic discharge system for children, which all staff could log in to and which supported the timely provision of information to local authorities and community services such as health visitors. A manual system was used for children who lived out of area.

Seven day service

- Patients had access to most services seven days per week. Some services had a reduced level of service provided out of hours but arrangements were in place to keep patients safe.
- Pharmacy support was available on the ward each day, Monday to Friday; out of hours arrangements were in place.
- Radiology services could be accessed seven days per week as required.

- Pathology services were provided seven days per week, 24 hours per day.
- Physiotherapy was available on weekdays and out-of-hours as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy on consent which included a section for obtaining consent from children. The policy described the specific considerations of the Gillick and Fraser competence and included links for further reading.
- Some of the staff we spoke with had a good understanding of gaining consent from children and the guidance around this with regard to a child's capacity to consent, however others had a limited understanding and this may have meant that decisions were made which were not in the patient's best interest.
- The staff we spoke with had an understanding of consent arrangements around a child's ability to make their own decisions, specifically Gillick competencies. (Gillick competency is used to help decide whether a child is mature enough to make their own decisions. The Gillick competency helps to balance children's rights and wishes with the trust's responsibility to keep children safe from harm).
- Some of the staff we spoke with understood the Mental Capacity Act 2005 and explained how they would assess a young person's mental capacity and a decision would be made in their best interest and recorded in their notes. However, not all staff, in particular the more junior members of staff (medical and nursing) understood the Mental Capacity Act and told us they would refer to a more senior member of staff if required. Therefore there was a risk staff may fail to identify when a person lacked capacity (parent, carer or child), and decisions may be accepted by a person where a best interest decision would have been more appropriate.
- The trust reported as at September 2016 that Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training had been completed by 37% of staff in children's services. MCA and DoLS training had been completed by 44% of medical and dental staff and 31% of nursing staff. This was below the trust target of 90%.
- Patients and their parents were supported by staff to make decisions. Staff and patients we spoke with told us how the procedures and treatment were explained to them and that they were told about different options available.
- Written consent could be obtained by the child and / or their parents for certain medical and surgical procedures and we saw examples of these.
- We noted that verbal and / or written consent was obtained for both medical and / or surgical interventions, with signatures obtained to confirm consent; consent was obtained from both the patient and their parent as applicable.
- Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment.
- The trust informed us a consent audit for children's services was not part of the forward plan for 2016- 2017, and no audit had been carried out in the previous 12 months. The trust added that it would be included in the forward plan for 2017/18.

Are services for children and young people caring?

Good

We rated services for children and young people as good for caring because:

- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner patients could understand.
- Patients and parents said they could be involved in care and treatment.
- Responses to the Care Quality Commission's 2014 children's and young people's survey were largely similar to, or better than other hospitals.
- Most parents or carers would recommend the service to their friends and family, although the percentage who would recommend was lower than the England average.
- There was a play specialist who provided additional support for children on the paediatric ward during their stay.

However:

- There were minimal psychology services available to patients and their families or carers.

Compassionate care

- Staff who worked on the paediatric ward, paediatric clinic and neonatal unit took the time to interact with patients and their parents in a manner which was respectful and supportive.
- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after. Patients and parents told us that communication had been good but they had mixed perceptions regarding the availability of staff. Some patients told us that staff seemed busy and their child wasn't always responded to quickly.
- We observed staff supporting and treating patients in a kind and caring manner.
- Patients had the opportunity to provide feedback via the NHS Friends and Family Test. The NHS 'Friends and Family' Test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across all NHS trusts.
- In September and October 2016 92% and 87% of children, parents or carers for babies admitted to the paediatric ward patients in paediatrics would recommend the service to their family and friends. Data had not been collected for the views of parents or carers for baby's admitted to the neonatal unit.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts for most of the questions posed and better than other trusts with regards to children receiving care and attention when needed as well as feeling listened to.
- Privacy and dignity of patients was observed to be respected at all times.
- Distraction techniques were used to divert children's attention from painful procedures and anaesthetic cream was used when taking blood from children.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with patients in a way that patients understood their care and treatment and condition. Staff recognised when patients needed additional support and did their best to provide this.
- All of the patients and relatives we spoke with on the ward and in the outpatients department told us that staff had communicated well with them and that they were satisfied with explanations provided about the treatment and care whilst in hospital. The trust scored better than average in the CQC's children and young people's survey 2014 for staff explaining what would be done during an operation or procedure and being given information about their condition to take home with them.
- Patients and parents said they could be involved in their own care and treatment if they wished. We observed interactions between staff, parents and their child and saw that staff spoke to children as well as their parents about what treatment they were providing and why.
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child.
- We were told by patients and staff that they understood where to seek further information if required and that children could talk to a member of staff without their parent present if they wished to do so.

Emotional support

- Staff understood the impact that a patients care, treatment and condition had on them and those close to them. Emotional support was provided by the staff, whilst caring for patients; however there was minimal formal support available. There was however, a professional psychologist available to provide counselling to patients with diabetes which had been funded by the commissioners. There was no psychological support for patients with other conditions who may also benefit from specialist support.
- For other patients and families, who may have been distressed, support was provided by the medical and nursing team, not specially trained professionals.
- There was a bereavement folder which included contact details for the hospital chaplaincy and provided details of religious preferences for a range of religions.
- One of the play therapists had received specialist training in supporting bereaved parents.

Services for children and young people

Are services for children and young people responsive?

Requires improvement

We rated services for children and young people as requires improvement for responsive because:

- The needs of local people had not been considered as part of the annual business planning cycle.
- The department became busy at times and activity had increased since the reconfiguration. The escalation policy had been followed but it was unclear how the increase in demand would be managed if the increase did not subside.
- Personal information for children with long term complex care needs lacked detail or had not been completed.

However:

- The care needs of individuals had been considered.
- There were arrangements in place for managing complaints.

Service planning and delivery to meet the needs of local people

- The public and other stakeholders were consulted about future services provided by the trust; however, the trust did not consider the needs of local people annually as part of their ongoing forward plans.
- West Midlands Clinical Senate had undertaken a review of the health economy in Worcestershire which had identified a need to reconfigure health services and this was put out to public consultation. The reconfiguration had taken place in stages, with neonatal and medical staff transferring from Alexandra Hospital to the Worcestershire Royal Hospital (WRH) in 2015 and the final closure of the paediatric ward in September 2016 when all staff transferred across to the WRH.
- We requested a copy of the business plan for 2016/17 for paediatrics and neonates as well as a copy of the plan for the previous year and achievement against performance. We were provided with a statement from the trust which confirmed that; 'The 2015/16 plan was based on centralising neonates and paediatric inpatients, which was achieved'. However, no supporting evidence was provided. The trust also stated that a business plan was; 'in development' for 2016/17. We were provided with a copy of the divisional plan.
- The divisional plan lacked detail and there was no information in relation to how the reconfiguration may impact on paediatrics and neonates service provision including the increase in demand, or how this would be managed. The plan failed to consider the needs of the local population, increase in demand because of transition as well as estimated population growth.
- The paediatric ward had separate bays for younger children and single sex bays for adolescents as well as some side rooms, this ensured single sex accommodation could be provided.
- Patients aged between 16 to 18 years old were offered the opportunity to be treated on an adult ward if they preferred, however, there was no oversight from the paediatric ward when young people under the age of 18 were admitted to wards outside of the paediatric service.

Access and flow

- The department became busy at times and activity had increased since the reconfiguration, although data was not available. This affected the paediatric ward in particular. Flow through the department did not always work well and the assessment area often exceeded capacity. There had been no detailed planning as to how this would be managed following the reconfiguration.
- Admissions to the paediatric ward were either via a planned admission process or through an emergency admission from a direct GP referral or through the emergency department (ED).
- Neonates were admitted via maternity as either a planned or emergency admission. Babies could be transferred from other hospitals if required.
- Following the recent reconfiguration, we were told by staff that there had been a significant increase in the number of patients being seen in the paediatric assessment bay. The bay consisted of three assessment beds as well as three seated areas and we were told that capacity was regularly exceeded and patients frequently waited in the corridor. We observed this happening. During the day the assessment area was staffed by a consultant (on bleep), junior doctor and one nurse. We were told that when the consultant was present, flow

through the department was smooth, but if the consultant was busy this impacted on the flow out of the assessment area and it became visibly 'clogged'. Patients were also assessed in the treatment room at times of overcapacity (an area to provide treatment for inpatients) which meant the room may not have been available for inpatient use. An audit on attendance to the assessment area had not taken place since reconfiguration.

- From our observations during the inspection we saw that the ward became full and during the unannounced inspection we were told that the ward had to close to admissions as there were no beds left. In addition, the paediatric ward had also closed to admissions on one occasion in November 2016; prior to this there had been no closures during the preceding 12 months.
- We were told that although the department could become busy at times, staff worked together to ensure patients' journey through the department worked well. Some patients with mental health needs could remain in the department longer than planned if they were waiting for a bed in a mental health unit but most patients were discharged back to the community team.
- During 2015/16 a total of 145 bed days were used by CAMHS patients due to unavailability of a mental health bed; there had been no increase since the previous year.
- From review of a sample of patient records, every child admitted to the paediatric department with an acute medical problem was seen by a doctor of the appropriate grade within four hours of admission in accordance with the Royal College of Paediatrics and Child Health, Facing the Future: Standards for acute general paediatric services. However, we were told that when patients were admitted over the weekend, review could take up to 17 hours.
- The neonatal intensive care unit (NICU) had cots to care for two intensive care (ICU) patients, four high dependency as well as 12 Special Care; two of the high dependency cots could be flexed for ICU use if required.
- During 2015/16 the average length of stay (LOS) for paediatric patients at Worcestershire Royal Hospital was just over one day for emergency patients and less than one day for elective patients which was similar to the England average. For neonates the LOS was an average of 12 days between the periods April to June 2015.
- We were told that although the department could become busy at times staff worked together to ensure patients' journey through the department worked well and that the reconfiguration had helped because staff were now located on one site. However, bed occupancy had increased since the changes which had impacted on bed availability. In response to this, the ward manager attended the daily bed meetings which previously they had not.

Meeting people's individual needs

- Services were planned which took into account the needs of different people. Consideration had been given to the patients' age and gender as well as any disabilities, although we noted that personal information about children with complex and long term care needs was out of date.
- During the 2015 inspection, we identified that there were no communication tools in place for patients who were unable to communicate verbally. A set of flashcards had been purchased and were held on the paediatric ward.
- The paediatric ward had a sensory room for patients with visual impairment as well as other patients who may benefit from this.
- Additional care plans were used for patients with learning disabilities and complex care needs. We were told that there were two completed copies, one which remained on the ward and a second copy which the patient took home with them. We reviewed a sample of those on the ward and found that they were mostly very out of date by some years and in some cases copies were held for patients who were now on an adult pathway.
- Translation services were available, although we were told that these were rarely needed. Some staff were also able to speak a second language and could be contacted via the hospital switchboard when on duty. If an interpreter or member of staff was not available telephone support could be accessed for translation although this was not the preferred option.
- Leaflets were not readily available in other languages. We were told that the PALS team could produce leaflets in other languages if requested; however, they were not frequently needed.
- There was a room available for patients to discuss confidential issues; this was also used as a lounge area for teenagers which meant that if a patient wished to discuss private matters, there was nowhere private for other teenage patients to relax.

Services for children and young people

- There was a playroom for young children that contained toys and books. There was a separate room for adolescents with DVDs, books, and a computer gaming system.
- The paediatric ward had four bedded bays which were separated by gender but there was insufficient space to separate patients by age. If patients were unhappy with the arrangements they could ask for a side room if one was available.
- Parents had the option to stay overnight with their child and 'put you up' beds were available on the paediatric ward. There was also a parents' room on the paediatric ward and NICU to accommodate parents in a more comfortable setting.
- There were limited facilities for parents visiting their baby on the NICU to make themselves a hot drink. There was one flat with a living room and two bedrooms, this had kitchen facilities, however, when occupied the living area which included a kitchen could not be used by other parents on the unit.
- Parking concessions were available for parents and carers visiting their child.
- There were suitable bathroom facilities for patients with a physical disability and adequate space on the ward to accommodate patients who used wheelchairs.
- Patients had access to a chapel and multi faith room on site.
- Patients who spoke other languages were supported by using a translation service by telephone or in person.

Learning from complaints and concerns

- There was a process in place for responding to complaints and information was available to make patients aware of how to make a complaint.
- There were complaints leaflets available for patients and their parents, details of how to make a complaint was also on the trust website.
- A small number of complaints were received about the paediatric and neonatal service. A total of six complaints had been received between the period 1 September 2015 and 31 August 2016; five for the paediatric ward and one for the neonatal unit.
- We were provided with summary information on the complaints received during this period. Two complaints had been responded to within the agreed timescale of 25 days, three had slightly exceeded the deadline by a few days and one had taken over 60 days for the family to receive a response.
- Complaints were discussed at the main governance meetings. There was a process for complaints to be discussed at team meetings; however, as there had been so few complaints, discussions were sporadic. Lessons learned were also shared in the monthly risk bulletin which was circulated to all staff.

Are services for children and young people well-led?

Inadequate

We rated services for children and young people as inadequate for well-led because:

- There was a lack of planning with regards to increased activity.
- There was a vision and divisional plan in place; however, this was not supported by clear objectives or actions.
- The governance framework was not effective. There was a lack of information flow between committees and meeting minutes lacked detail around the content of information presented.
- The risk register had failed to incorporate significant risks.
- Feedback about the service was not consistently acted on.
- The response rate for the friends and family survey was lower than the England average and people were less likely to recommend the service.

However:

- Staff felt well supported by management at a local level.
- Care provided was patient focussed.

Leadership of service

- Leaders were visible and approachable; ward managers understood some of the challenges at a local level. However, there was a lack of planning with regards to increased activity following the reconfiguration.
- There was an accountability structure in place; nursing staff on the wards reported to the ward manager who in turn reported to the matron for paediatric inpatients.
- The outpatient service was overseen by a paediatric outpatient manager who had responsibility for management of outpatients at each of the trust's three locations, although they were based only at

Worcestershire Royal Hospital (WRH). We were informed that although the outpatient manager was responsible for the entire paediatric outpatient service, they had not been allocated protected time for their managerial duties and worked clinically all of the time.

- We observed the wards and departments were managed on a day to day basis with good leadership at a local level, staff allocations were made appropriately. However, staff told us and we observed that the paediatric ward in particular became very busy at times and the assessment area frequently exceeded capacity.
- Medical staff reported to the clinical director. More junior staff were supported and supervised by the consultants.
- There were consultant leads for specific services within paediatrics and neonates. For example, there were leads for oncology, diabetes, respiratory, endocrinology and epilepsy management.
- There were nurse leads for diabetes, respiratory and epilepsy.
- Job plans were in place for all consultants; these had been completed between the period March and July 2016.
- The staff we spoke with told us that they had good working relationships with their managers and felt able to raise concerns if they needed to and that on the wards they regularly saw their local managers.
- Until recently the paediatric management team had not been represented at the trust's daily bed management meetings. Due to the increase in activity, the matron had insisted paediatrics were represented at these meetings to ensure the trust were aware of the bed state on the ward.

Vision and strategy for this service

- The service did not have a clear vision; a divisional plan had been developed which was linked to the trust priorities, however these were not supported by clear actions or timescales and had not been assigned to a lead.
- The trust values were Patients, Respect, Improve, Dependable, and Empower (PRIDE). Some of the staff we spoke with, but not all, were able to tell us what the values were.
- The values were underpinned by a strategic vision to deliver safe high quality care, realise staff potential and ensure financial viability.
- In July 2015, the date of our previous inspection we identified that there was no business plan for paediatrics/neonates and instead paediatrics had been incorporated into a one page divisional plan, which lacked detail. When we re-inspected in November 2016, there had been no improvement. We were provided with a statement from the trust that stated that a departmental plan was in progress.
- Review of the divisional plan confirmed it was linked to the trust's four key priorities; investing in staff, delivering better performance and flow, quality and safety and stabilising finances. The plan had not been improved since our previous inspection and still lacked detail as it was generic in nature. 'Deliverables' and 'measurables' had been documented and were linked to the four priorities. There was insufficient information within the plan for these to be actioned and realised in a meaningful way. It was also difficult to establish which measurable was linked to which objective. An example of one deliverable was: 'transparent, efficient incident and complaints processes and eliminate back-log of open incidents.' The measure for this was; 'complaints compliance to 25 day standard and 100% acknowledgement in 3 days' and for '90% serious incidents investigations and reports completed within timeframe.' However, it was unclear why there was an issue with the transparency or delays in the first instance. There was no clear action as to how this would be improved or how the measures would be achieved. In addition, the current position had not been stated. We also noted that some deliverables did not relate to the department, for example one was; 'time from arrival in emergency department to admission, transfer or discharge is no more than four hours'.

Leads that were responsible for delivering the divisional plan had not been allocated timescales had not been set.

Governance, risk management and quality measurement

- There was a governance framework in place, however, this was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings. Meeting minutes lacked detail and agenda items were not

always included in accordance with the committees' terms. Significant risks had not all been recorded on the risk register. We identified and reported on similar concerns in the July 2015 inspection.
- There was a women and children's monthly governance (WCGM) meeting as well as a children's directorate quality improvement committee (QIC) which also met monthly.
- Both committees were independent of each other and there was no formal approach for information to flow between them.
- The WCGM was tasked to ensure all aspects of governance were defined and monitored for paediatrics, neonatal care and obstetrics and gynaecology, in accordance with its terms of reference. Similar responsibilities were defined for the QIC at a directorate level.
- During the July 2015 inspection we identified that the WCGM had not consistently discussed all standing agenda items in accordance with its terms and this had not improved. For example, there was no discussion around training and competencies of staff.
- We also noted that there had been little improvement recording information in the minutes for example, discussion around incidents still focussed on the numbers and the length of time they took to be completed, rather than themes and trends. Similarly discussion which took place about the divisional risk register focussed on the number of risks recorded rather than how they were being managed. As an example, the September 2016 minutes recorded; '16 open moderate/ high cases. As of today there are 15 moderate cases as 2803 was closed. 4 moderate risks with no actions. Overdue actions will be reviewed by end of September'. There was no record of which directorate the risks related to, what they were and whether they were being managed effectively.
- Review of the QIC minutes for September and October 2016 both included standing agenda items in accordance with its terms. There was evidence of worthy discussion around some items presented but not all. There was a process in place to carry actions forward to the next meeting.
- During the July 2015 inspection we noted that there was a lack of discussion around incidents, in particular themes and trends or categorisation of incidents and we saw no improvement in November 2016. Similarly we had also noted a lack of discussion around the risk register with focus on closing the risk rather than the content of ongoing risks being managed and discussed. There was no discussion around the clinical dashboard.
- There had been some improvement in relation to presenting the dashboard, however, minutes listed areas where underperformance had occurred as highlighted in the dashboard, but there was no further detail around how this could be improved or possible reasons for the underperformance.
- We also noted that although the Alexandra Hospital location had recently closed to paediatric inpatients, there had been no discussion around how the transitional period was being managed.
- There were nine risks recorded on the paediatric risk register (including neonatal unit). Each risk had been scored according to its likelihood and impact, with mitigating controls documented if they were in place. Some risks had been described in detail, with good controls to ensure the risk was managed. We saw that improvements had been made since the previous inspection in July 2015 because many of the long standing risks had since been reviewed and closed or reviewed and revised.
- During our inspection we identified additional risks which had not been added to the risk register, for example, the increase in demand from the recent reconfiguration including the pressures this placed on staff as well as logistics and risk to patients.
- The clinical audit plan for 2016/17 was approved at the May 2016 WCGM. There was evidence in the September minutes that medical staff were being reminded that if they wished to undertake additional audits that these were added to the audit plan, which we had identified as an issue in the previous inspection. There had been no completed audits presented at the September or October 2016 meetings and there was no meeting held in August.

Culture within the service

- The service was supportive of staff and care provided was patient focussed.
- Staff told us there were good working relationships amongst their peers as well as other disciplines and that WRH was a pleasant place to work. Staff at all levels told us how there was excellent teamwork throughout the departments and that medical staff always took time to listen to concerns of nurses or support staff.

- Staff told us that they were encouraged to report incidents and that they felt confident in doing so. In addition they emphasised the importance of sharing information with patients and families when an incident occurred, which involved them.
- During the July 2015 inspection we identified concerns with the relationships between GP trainees and nursing staff. The medical and nursing staff we spoke with reported that working relationships were positive and there had been no further concerns.

Staff engagement

- An annual staff survey took place each year to gauge staff perception on a range of matters. We requested a copy of the action plan for paediatrics. However, the action plan provided was trust wide and therefore we were unable to link this directly to the satisfaction of staff working within the paediatric and neonatal departments. This was also identified during the July 2015 inspection.
- We were told that staff were able to raise any concerns as part of the daily handover or as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with managers.
- Staff were given the opportunity to provide feedback about their working environment each quarter by completing a 'chat back' survey. The trust provided results from the June 2016 survey. The response rate for the division was 7% compared to a trust wide response rate of 14%. The trust had set a target of at least 66% positive responses and had achieved 61% for paediatrics overall, which was close to target. In the survey, 100% of staff reported that they had not felt bullied or harassed or experienced physical violence from a colleague. Only 27% of staff reported that communication between senior management worked well and that they felt valued by management. We requested a copy of the action plan but were informed that this would not be completed until the end of December 2016.

Public engagement

- The views and experiences of patients and those close to them were gathered through surveys and comment cards but were not consistently acted on.
- Patients were given the opportunity to provide feedback using comment cards and more as well as via the friends and family test. We reviewed a sample of twenty comment cards, the comments we reviewed were largely positive and we saw examples of action taken, if appropriate when negative comments were received.
- Patients also had the opportunity to provide feedback via the NHS Friends and Family Test. Response rates were low for the paediatric ward and data had not been gathered for the neonatal unit. In September and October 2016 the response rate for the paediatric ward was 7.3% and 8.2% respectively which is much lower than the England average for all inpatients at 25%. Feedback received was also lower than the average, with 92% of respondents reporting they would recommend the service in September 2016, this dropped to 87% in October 2016 with 3% and 6% stating they would not recommend the service in September and October 2016. These figures compared to the national average for all inpatients of 95% would recommend the service and 2% who would not recommend the service.

Innovation, Improvement and Sustainability

- The unit has not considered the sustainability of the transformation and this has not been monitored since it had taken place.
- We were not aware of any specific examples where financial constraints (beyond the transformation) had impacted on patient care.

End of life care

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

Information about the service

Worcestershire Royal Hospital (WRH) is part of Worcestershire Acute Hospitals (WAH) NHS Trust. Patients at the end of life were nursed on general hospital wards. From April 2015 to March 2016 there were 129,580 in-patient admissions and 1,840 in-patient deaths across all hospital sites of which 1212 were at WRH. From April 2015 to March 2016 there had been 2,259 referrals to the specialist palliative care team, of which 49% were for patients with cancer and 46% for those with non-cancer.

The Alexandra Hospital was also visited as part of this inspection process and end of life care in each hospital is reported upon separately. End of life care services on both hospital sites are run by one management team. As such they are regarded within and reported upon by the trust as one service, with some of the staff working at both sites. For this reason it is inevitable there is some duplication contained within the reports.

The specialist palliative care (SPC) team was made up of 1.5 whole time equivalent (WTE) consultants in palliative medicines posts; this included the lead consultant who was based at the Alexandra Hospital. There were 10 post holders to 6.93 WTE SPC clinical nurse specialists (CNSs) across the trust as a whole. Six CNSs which were based at WRH. In addition there were two end of life care facilitators employed by the trust, one of which was based as WRH.

During this inspection we visited a number of inpatient wards and clinical areas including stroke, acute medical unit, elderly care, respiratory, emergency department, general medicine, cardiology, gastroenterology and general surgery. In addition we visited the chapel, multi-faith room, the bereavement office, and the hospital mortuary. We observed care and viewed eleven care records including those where patients were being cared for using the Optimising End of Life Care Plan or where the AMBER care bundle was in use. We spoke with two patients and one relative. We also spoke with a range of staff including the SPC consultant and lead nurse, SPC clinical nurse specialists, end of life care facilitators, bereavement officers, the chaplain, a mortuary manager and technician, a porter, ward based medical and nursing staff and a discharge liaison nurse. In total we spoke with 30 staff members. We looked at policies and procedures and reviewed performance information about the trust.

End of life care

Summary of findings

We rated the end of life care service as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- The trust had taken action to improve the facilities in the mortuary since a previous inspection. This included replacing fridges, flooring and improving the hot water facilities.
- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life. A comprehensive programme of end of life care training was available for the full range of staff within the trust.
- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members. The specialist palliative care team provided a seven day face to face assessment service across the trust.
- People were supported, treated with dignity and respect and told us they felt involved in their care. We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. People we spoke with were complimentary about the staff and told us they felt appropriately supported.
- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent. The majority (92%) of patients were seen within 24 hours and there was a good balance between cancer and non-cancer referrals.
- The specialist palliative care team worked proactively with emergency department to identify patients who may benefit from palliative care input.
- The trust had begun to record and audit preferred place of care at the end of life and there were clear systems in place to make improvements in this area.
- The specialist palliative care team had audited complaints that had an end of life care component, identified trends and had taken action to address improvements.
- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.
- There was consistent promotion of the delivery of high quality person centred care and strong leadership for end of life care. Staff were consistently passionate about end of life care, positive about their roles and consistent in their belief that the quality of end of life care was good.
- Innovations included close working between the specialist palliative care team and emergency department staff to identify patients at the end of life and provide specialist support. The trust was one of ten that had been chosen to participate in a quality improvement partnership with The National Council for Palliative Care and Macmillan Cancer Support.

However:

- Discussions around DNACPR (do not attempt cardiopulmonary resuscitation) decisions were not always sufficiently recorded within patient's medical records.
- Feedback from relatives and staff showed there had been some delays in obtaining death certificates, although we saw that this had been discussed at the meeting of the bereavement group and we were told the lead nurse was taking the lead on addressing this issue.

End of life care

Are end of life care services safe?

Good

We rated end of life care as good for safety because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- Equipment was generally available for the care of patients at the end of life.
- The trust had taken action to improve the facilities in the mortuary since a previous inspection. This included replacing fridges, flooring and improving the hot water facilities.
- Issues relating to obtaining syringe drivers had been addressed by changing the system for obtaining them after this had been identified as an area of risk on the service risk register.

However:

- Recording of discussions around DNACPR decisions were not always provided in sufficient detail.
- We were not able to establish specialist palliative care staff's compliance with mandatory training (including safeguarding adults training) as this evidence was requested but not provided by the trust.

Incidents

- Incidents were reported using an online reporting tool. Staff we spoke with had a good understanding of the process for reporting incidents and we viewed examples of where incidents involving end of life care had been reported.
- From October 2015 to September 2016 the trust reported no incidents which were classified as never events for end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from October 2015 to September 2016.
- Staff were aware of their responsibilities in reporting incidents and all incidents that included an element of end of life care were reviewed by the trust lead for palliative and end of life care.
- An audit of end of life care related significant events identified that 40% of incidents were related to issues of patient flow throughout the trust. As a result the specialist palliative care team had taken action to work proactively on a daily basis with emergency department staff to improve patient flow for those at the end of life. A specific example we were given of where this work was focused was in relation to patients from nursing or care homes who were identified as not requiring an acute hospital bed. Nursing staff from the specialist palliative care team would liaise with the care and nursing homes where it was appropriate for the patient to return.
- Staff we spoke with had an awareness and understanding of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Environment and equipment

- There was a mortuary at Worcestershire Royal Hospital (WRH). We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. The mortuary was manned by a team of four staff. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- Following the inspection of the service in July 2015 the trust had addressed issues identified with faulty refrigerated storage units in the mortuary by replacing them with new units. In addition, they had replaced the flooring and waste bins and had increased capacity. In

response to issues relating to the supply of hot water to the mortuary the trust was installing a new hot water tank to provide a permanent solution at the time of our inspection.

- The mortuary fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We observed the use of syringe drivers (a battery powered pump that delivers continuous medicines through a tube placed under the skin) on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were generally available when they needed them. However, we noted that access to syringe drivers in a timely way had been identified on the trust risk register. Staff we spoke with told us the system for accessing syringe drivers had been reviewed and updated to ensure that access was as efficient as possible. No staff we spoke with reported delays in accessing syringe drivers at the time of our inspection.

Medicines

- Medicines were prescribed using clinical guidelines which were easily accessible on the trust's intranet. The guidance included different treatment options for a range of symptoms that could be experienced at the end of life.
- Medicines for use at the end of life, including those for use in a syringe driver were readily available on the wards. Nursing staff said that end of life care medicines were accessible, including outside of normal working hours if required through an on call pharmacist. However, staff told us that there were generally adequate stocks of end of life care medicines available on the wards.
- We viewed the medication and medical records of eleven patients at the end of life and saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice and had attended training relating to anticipatory prescribing. They also told us that the specialist palliative care team were available to provide advice and support around appropriate prescribing, particularly in complex cases.
- There were systems in place within the mortuary for the safe storage, monitoring and disposal of medicines. Medicines were stored in a locked safe and returned to pharmacy for destruction. Records of this were maintained.

Records

- The trust had developed an Optimising Care at the End of Life Plan. This had been implemented following an initial pilot in 2014. Staff told us the plan had been in use for 18 months and was embedded into practice in many areas. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed comprehensively.
- Care plans reflected national guidance and records included risk assessments, such as those for the risk of falls, pressure area damage and nutritional screening.
- The trust used a combination of paper and electronic patient record systems. Records we viewed were stored securely and written comprehensively.
- We reviewed 11 DNACPR (do not attempt cardiopulmonary resuscitation) forms and saw that these were generally completed accurately and comprehensively. All were dated, stored in the front of the patient's medical notes and included clearly recorded decisions and clinical information. We reviewed 11 medical records and 10 were appropriately signed. Discussions with patients and relatives were recorded on the form and in some cases in further detail in the medical notes; however this was not always consistent. For example, four of the 11 DNACPR forms indicated that a discussion had taken place; however the recording of discussions were not provided in sufficient detail.
- Records within the mortuary were comprehensive and included processes for appropriate checking of identification.

Safeguarding

- Staff we spoke with demonstrated an understanding of safeguarding procedures within the trust. For example, we observed interactions between the end of life care facilitator and ward staff where they discussed a safeguarding concern for a patient at the end of life. The discussion included a referral to the safeguarding team.
- In the last 12 months 99% of trust-wide staff had attended safeguarding adults training.

End of life care

- Evidence was requested to support that specialist palliative care staff had attended safeguarding adults training, however this was not provided by the trust. Safeguarding issues were considered as part of regular multi-disciplinary discussions.

Mandatory training

- Evidence was requested to support that specialist palliative care staff had attended mandatory training, however this was not provided by the trust.
- Trust wide nursing and midwifery staff had a 2016 training completion rate that was meeting or exceeding the trust target of 90% for fire awareness, infection control, information governance and resuscitation training. Medicine management, conflict resolution and equality and diversity had a completion rate below 50%.
- The trust used a combination of face to face and electronic learning packages for staff in relation to end of life care. End of life care was considered to be essential rather than mandatory training for clinical staff.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of malnutrition and dehydration and the risk of pressure damage.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the Optimising Care at the End of Life framework when they were expected to die within a few days.
- The AMBER Care Bundle was in use throughout the trust, a tool used to support the identification of patients at risk of dying within the next one to two months. AMBER provided a framework for assessment of the patient's medical plan including their resuscitation status and decisions about treatment escalation. This enabled staff to manage end of life care risks more proactively, for example in relation to keeping patients comfortable and ensuring that opportunities for meeting their wishes were taken.
- Patients identified as being at the end of life were reviewed every few hours by nursing staff on the wards and as a minimum daily by medical staff. Ward staff told us they had access to the specialist palliative care team who responded quickly when needed.

Nursing staffing

- The specialist palliative care team across the trust included 10 (6.93 whole time equivalents) specialist palliative care clinical nurse specialists (CNSs) and two end of life care facilitators. There were six specialist palliative care nurses and one end of life care facilitator based at Worcestershire Royal Hospital.
- The specialist Palliative Care team provide face to face assessments of patients from 8.30am to 4.30pm, seven days per week. Monday to Friday there was a team based at the Alexandra Hospital and one based at Worcestershire Royal Hospital. On Saturdays and Sundays there was one CNS on duty who covered both hospitals and was available by air page.
- Specialist palliative care nurses worked closely with ward based nurses and there were end of life care link nurses/champions on each ward. End of life care link nurses had received additional training and support from the specialist nurses to carry out their role and were available as a resource to other nursing staff on the wards.
- Staff told us they prioritised care for patients at the end of life as much as possible by ensuring that staff were available to meet the needs of both the patient and their relatives.

Medical staffing

- The trust had two consultants in palliative medicine across all hospital sites. One (0.6 whole time equivalent) was based at Worcestershire Royal Hospital (WRH). In addition there was a full time specialist registrar working in the team who was also based at WRH. The trust also had speciality trainee doctors working with the specialist palliative care team from time to time.
- There was 24 hour on call palliative care consultant cover and out of hours advice was available from local hospices.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team.

End of life care

- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals. All referrals were responded to within 24 hours.

Major incident awareness and training

- The trust had a major incident plan that included a system for chaplaincy support and arrangements for the use of the mortuary.
- Staff working with the palliative care team had an understanding of the major incident plan.

Are end of life care services effective?

Good

We rated effective as good because:

- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life including the AMBER care bundle and an evidence based Optimising Care at the End of Life document.
- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members.
- The specialist palliative care team provided a seven day face to face assessment service across the trust.
- The trust had participated in the National Care of the Dying Audit (NCDAH) and made use of audits in other areas to identify and address areas for ongoing improvement.
- End of life care training was available for the full range of staff within the trust and the specialist palliative care team and end of life care facilitators made the most of both formal and informal learning opportunities to ensure all essential staff were appropriately trained.
- There was evidence of mental capacity assessments and consideration of Deprivation of Liberty Safeguards for patients who lacked the mental capacity.

However:

- We were not able to establish whether specialist palliative care staff had received annual appraisals, as this evidence was requested but not provided by the trust.

Evidence-based care and treatment

- The trust had introduced an Optimising Care at the End of Life plan in 2014. The plan been developed to include national guidance sources such as the Leadership Alliance for the Care of Dying People and the National Institute for Health and Care Excellence (NICE).
- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The specialist palliative care team monitored national guidance and ensured end of life care tools in use within the trust were reflective of current recognised practice such as NICE Care of the Dying Adults in the Last Days of Life (NG31) 2015.
- A specialist palliative care operational policy included reference to national guidance. Minutes from a 'High Impact Action Group – End of Life' meeting dated 13 June 2016, included evidence of discussion of national guidance and its relevance to the care of patients at the end of life.
- The trust used the AMBER care bundle, a national tool used to support the identification of patients at risk of dying within the next one to two months. This approach was used when clinicians were uncertain whether a patient may recover and provided a framework to consider care at the end of life and the involvement of the patient and family members in this while continuing to actively provide treatment.

Pain relief

- Members of the specialist palliative care team had attended courses and attained qualifications in symptom control and pain management.
- Doctors we spoke with were aware of the guidance around prescribing for key symptoms at the end of life. They knew they could access the guide on the intranet and also seek support from the specialist palliative care team.
- Patients and relatives we spoke with told us that staff were quick to respond when patients experienced pain and other symptoms. Nursing staff were proactive in assessing levels of pain and other symptoms on a regular basis. Nurses used a zero to 10 sliding scale to assess pain. We did not see other types of pain assessment tools in use; however staff told us they also took account of body language and facial expression when assessing pain.

End of life care

- Care plans included pain assessment prompts and clear records of pain assessments.
- Anticipatory medicines were prescribed appropriately for patients at the end of life.
- The specialist palliative care team had been successful in a bid to participate in the Building on the Best quality improvement partnership with The National Council for Palliative Care and Macmillan Cancer Support for acute hospitals. The focus of this bid was to improve pain and symptom management for patients with palliative and end of life care needs and the project was due to start in early 2017.

Nutrition and hydration

- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that. Staff demonstrated an awareness of guidance in supporting nutrition and hydration in end of life care.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care. Regular mouth care was incorporated, as well as involvement of the family and the need to be led by the patient in terms of what they could and could not eat and drink.
- CNSs and end of life care facilitators worked with ward staff to increase awareness around end of life care nutrition and hydration issues. We observed a member of the specialist team discussing the use of a 'nil by mouth' sign for a patient at the end of life where this appeared to be in use because the patient was unconscious. The focus of advice was around using alternative terminology to 'nil by mouth' unless there is clinical reasoning for it and to consider the implications of a 'nil by mouth' order in the instance that the patient may wake up.
- The specialist palliative care team were represented at an artificial feeding multidisciplinary meeting where the use of artificial forms of feeding was discussed for each patient being considered for it. The decision making process included meeting with the patient and family to involve them in discussions.
- Patients and relatives we spoke with told us they had been involved in discussions about food and drink and ways to meet patient's needs and maintain comfort.

Patient outcomes

- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and there was evidence of improvements in meeting the standards when compared with the 2014 results.
- There was evidence of improved performance in relation to organisational indicators where all had been achieved. The trust performed better than the England average for three of the five clinical indicators. The trust had developed an action plan to address the areas where improvements were needed that included improving communication skills training for staff, such as the recently implemented Sage and Thyme communication training offered by the specialist palliative care team. This training supported staff to better respond to people who are distressed. The team were also exploring the use of advanced communication skills training and whether this needed to be expanded to cover different staff groups.
- As part of the audit process the trust identified there had been an 8% increase in the use of the AMBER care bundle and a 14% increase in the use of the end of life care pathway over a 12 month period. There had been an 8% increase in discussions about preferred place of care at the end of life and a 21% increase in documented advance care planning. This demonstrated an improvement in the adoption of the end of life care guidance available to staff in the trust.
- End of life care champions on the wards participated in audit of the use of the AMBER care bundle and had received training relating to this.

Competent staff

- The palliative care nursing team were skilled in end of life care issues and had completed training in areas such as symptom management, advanced communication skills and independent prescribing. The team received regular clinical supervision.
- There were end of life care champions on every ward, with some clinical areas having two or three champions. The champions attended meetings and training specific to their role and could access enhanced end of life care training and support from the specialist palliative care team including accessing shadowing opportunities.
- The team provided a range of formal training to general staff caring for patients at the end of life. This included mandatory and essential training such as on induction

or preceptorship courses. End of life care facilitators also ran palliative and end of life care workshops for different groups of staff, care after death training and healthcare assistant certificate courses.

- In recognition of the difficulties presented with staff leaving clinical areas to attend training, the end of life care facilitators also provided ward based training for staff. We viewed certificates given to ward staff and porters on the integrated care after death pathway training where this was carried out opportunistically on the ward areas. In addition, the specialist palliative care team had identified that nursing staff would benefit from additional syringe driver training and had conducted a series of 'drop in' sessions in the hospital foyer for those finding it difficult to attend formal training.
- Junior doctors we spoke with told us they had attended end of life care training within the trust including communication training and anticipatory prescribing at the end of life.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- Porters received training on induction and on an ongoing basis from mortuary staff around the transfer of the deceased to the mortuary. This included aspects of dignity and respect and well as communication with the bereaved.
- Evidence was requested to support that specialist palliative care staff had received annual appraisals, however this was not provided by the trust.

Multidisciplinary working

- The specialist palliative care multidisciplinary team (MDT) was led by a lead nurse and lead clinician. It consisted of consultants in specialist medicine, palliative care clinical nurse specialists (CNSs), end of life care facilitators, social support services, allied healthcare professionals, spiritual support, bereavement support, pharmacy support, pain specialists and other clinical nurse specialists.
- Weekly MDT meetings were held where trust specialist palliative care staff would attend to discuss their most complex patients. These meetings were video linked across hospital sites. We observed a meeting taking place and saw that issues relating to risk, preferred place of care, symptom management and patient choice were all discussed.
- There was a clear process for the transfer of care from hospital to community services, including for care plans and medication. Effective communication between hospital specialist staff, community specialist staff and hospice staff was established through the existing multidisciplinary relationships.
- There were monthly specialist palliative care face to face business meetings and additional operational meetings that were undertaken.
- There was access to specialist allied health professionals such as occupational therapy, physiotherapy and speech and language therapy.
- Specialist palliative care staff would attend regular ward based meetings as part of their routine visits to review patients on the wards. This enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.
- The specialist palliative care team worked closely with cancer and non-cancer specialist teams and palliative care consultants would attend regular MDTs to provide input.

Seven-day services

- Palliative care clinical nurse specialists provided a seven day face to face service between 8.30am and 4.30pm, Monday to Sunday. This consisted of two specialist teams at Worcestershire Royal and Alexandra Hospitals from Monday to Friday. There was an on-call CNS available to provide face to face assessments on Saturdays and Sundays.
- Allied healthcare professionals provided an urgent service over the weekend for those patients who needed it.
- Mortuary staff were on-call out of hours.
- The chaplaincy service provided multi-faith and no faith pastoral and spiritual support 24 hours a day, seven days a week via and on call service.
- Consultants in palliative medicine were on-call via a locality rota 24 hours day, seven days a week.

Access to information

End of life care

- There were end of life resource folders kept on wards and in clinical areas, providing staff with information on symptom management, end of life care and how to access specialist services both in and outside of normal working hours.
- Ward based end of life care link nurses attended regular meetings with the specialist staff and participated in maintaining information in the clinical areas to ensure it was up to date for both patients and staff.
- The electronic patient record system enabled sharing of information across services, including with patients' GPs.
- The specialist nurse and end of life care facilitators attended the wards on a daily basis to review patients and provide support to ward staff. This included sharing up to date evidence based information in planning and delivering care to patients, particularly around symptom management.
- We saw that information was clearly recorded in patient's care plans. The specialist palliative care team entries into patient records were clearly identifiable through a sticker system so as to be easy for ward staff to access recommendations and specialist advice.
- The trust was planning on introducing the EPaCCS (electronic palliative care co-ordination system) by the beginning of 2017. This enables recording and sharing of people's care preferences and details about their care at the end of life.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a clear understanding of consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We observed an example of a patient who lacked capacity receive a referral for an independent mental capacity advocate.
- Five of the 11 DNACPR (do not attempt cardiopulmonary resuscitation) records we viewed were for patients who did not have mental capacity. In three cases we saw clear evidence of a record of a mental capacity assessment but not in the other two. In all cases there was clear evidence of involvement of the family in best interest decision making.
- DNACPR decisions were made appropriately and in line with national guidance. The trust were aware of developments in guidance relating to this and regularly audited DNACPR records. We viewed an audit from March 2016 that demonstrated forms were appropriately completed in more than 90% of records.

Are end of life care services caring?

Good

We rated caring as good because:

- Patients and relatives were supported, treated with dignity and respect, and told us they felt involved in their care. Where survey results showed room for improvements in terms of communication, the specialist palliative care team took action to address this.
- We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. Patients and relatives we spoke with were complimentary about the staff and told us they felt appropriately supported.
- There were examples of where staff went out of their way to support patients and their families at the end of life, including arranging ward based weddings.
- Survey data showed that relatives of those who had received end of life care at the trust were satisfied with the support they received from staff.

Compassionate care

- Staff were seen to be caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.
- Patients and relatives we spoke with shared their experiences of end of life care at Worcestershire Royal Hospital. We were told that staff were courteous and helpful and took time to speak with patients and relatives. Patients and relatives were satisfied with the care provided.
- We spoke with two patients and two relatives during our inspection. Patients and relatives were positive about their experience of care. We heard that staff were kind and caring and that communication with patients and relatives was clear, open and empathetic.

End of life care

- The trust offered a VOICES (National Survey of Bereaved People) questionnaire to bereaved relatives and carers of deceased patients over the age of 18, for whom a death certificate was issued during the period 1st April to 30th June 2016. The sample excluded those patients who died in the emergency department, children under the age of 18 and those who experienced a sudden death. The results of the survey showed that 96% of respondents were satisfied with communication and emotional support offered to them. 98% felt that dignity and respect were maintained and 93% felt that the level of privacy was appropriate. However, the most recent survey report (January to March, 2016) showed there had been a decline in relative's experience in some areas. For example, in the number of respondents feeling they had been given the opportunity to talk about their loved one's care or any concerns that they may have had. The specialist palliative care team had identified this slight decline and as a result had taken action to address some of the issues in essential staff training.
- Specialist palliative care nurses had been trained in advanced communication skills and communication skills training was available for all staff.
- Where possible patients at the end of life were cared for in a side room. Staff told us that this was sometimes difficult as side rooms were also used to manage infection control but that there was clear prioritisation and the views of the patient and relatives were considered.
- We were given examples of where staff went out of their way to support patients and their families at the end of life. This included arranging a ward based wedding for the daughter of a patient at the end of life and arranging for another patient to renew their wedding vows.

Understanding and involvement of patients and those close to them

- Patients we spoke with and their relatives told us they felt involved in their care. They told us that staff communicated with them sensitively and that they were given the time they needed to make decisions about their care.
- Relatives we spoke with told us they felt involved in their loved ones care. Results from the VOICES bereavement survey showed that 91% of relatives stated that they felt involved in decisions about care. This was an improvement of 9% from the 2014 survey. 88% of respondents stated they felt that personal wishes were respected which meant that earlier discussions regarding care were held.
- The trust had increased the use of advance care plans in the past 12 months as demonstrated in regular audits.

Emotional support

- Clinical staff received training in communication skills including training for supporting people in distress. The trust had a chaplaincy and clinical psychology service available.
- The chaplaincy service provided spiritual support for patients and their families. A team of volunteers worked with the on-site chaplain to provide this. This support included face to face contact with patients and relatives such as out of hours support when a patient has died or is in the last hours of life.
- The trust's bereavement service found that 98% of respondents felt they had received appropriate emotional support from staff.
- We spoke with two patients and two relatives being supported at the end of life and all told us they had received appropriate emotional support from staff.
- A carer's support worker was available at Worcestershire Royal Hospital to provide emotional support and practical advice to carers and family members of patients at the end of life. This included making appropriate referrals, providing advice and sitting with carers and relatives and giving them an opportunity to talk.
- There were volunteers available within the emergency department to provide support to bereaved relatives. This included sitting with them and offering emotional support.

Are end of life care services responsive?

Good

We rated responsive as good because:

- The specialist palliative care service worked collaboratively with other services and organisations to ensure that services were planned and delivered to meet the needs of local people.

End of life care

- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent. 92% of patients were seen within 24 hours.
- There was a good balance between cancer and non-cancer referrals to the specialist palliative care team, with patients with cancer making up 49% of referrals and those with non-cancer 46% and the remaining 5% unclassified.
- The specialist palliative care team worked proactively with the emergency department to identify patients who may benefit from palliative care input.
- The trust had begun to record and audit preferred place of care at the end of life and there were clear systems in place to make improvements in this area.
- Discharge coordinators were available to support the process of rapid discharge at the end of life.
- The specialist palliative care team had audited complaints that had an end of life care component, had identified trends and had taken action to address improvements.

However:

- Feedback from relatives and staff showed there had been some delays in obtaining death certificates, although we saw that this had been discussed at a the meetings of the bereavement group and we were told the lead nurse was taking the lead on addressing this issue.

Service planning and delivery to meet the needs of local people

- A Worcestershire end of life care network met regularly every three months and included representation from the trust and a range of county wide services. In addition consultants in palliative medicines across the county met regularly to discuss county wide developments to meet the needs of local people.
- Services were planned to meet the needs of the local demographic and a primary aim of the end of life networks was to raise awareness of end of life issues and ensure that patients received care in line with their wishes and preferences.
- There was an emphasis within both the specialist team and on general wards to support patient's to die in their preferred location. The trust had not previously collated data relating to the percentage of patients who died in their preferred location. However they were beginning to do so and had initial figures relating to this. A February 2016 audit showed that 74% of patients had no preference recorded in their records. Of the 26 patients where their preference was recorded, 62% had achieved their preferred place of care at the end of life.
- The February 2016 audit of in-hospital deaths showed a small increase (6%) from the previous year in the percentage of patients who had died where a conversation about preferred place of death had been recorded.
- The specialist palliative care team had developed a tool to identify the preferred place of death of patients on the team's active caseload. They had also added preferred place of care discussions to all of their training and educational activities to raise awareness among ward based staff. Ongoing annual audits of preferred place of death were planned.
- There were no designated beds for people receiving palliative care. Side rooms were available although we were told that the use of these for patients at the end of life was secondary to their use in the management of infection control.

Meeting people's individual needs

- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible. The trust scored similarly to the national average in relation to the identification of patients at the end of life as part of the 2016 National Care of the Dying audit.
- Discharge liaison nurses were available to support the process of getting people home, including for those patients at the end of life. Staff told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- An advance care planning 'future care' booklet was available to patients and their families. An audit of the records of patients at the end of life showed there had been a 21% increase in the recording of advance care plans for patients at the end of life.
- Translation services were available 24 hours a day. There were specialist nurses within the trust for both learning disabilities and dementia.

End of life care

- There was a multi-faith chapel and prayer room available with information about different faiths and religions. The mortuary service had a policy to deal with deaths of those from different faiths and cultures and staff gave us examples of when this had happened.
- Mortuary viewing facilities were appropriate and there was a system in place where relatives would be escorted to the mortuary by bereavement staff. Relatives were also able to view outside of normal operating hours where the senior staff on duty would arrange for them to be supported to do this.
- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.

Access and flow

- Referrals to the specialist palliative care team came through from ward staff and a good deal were picked up through routine ward visits. Ward staff told us the team always responded promptly and that urgent referrals were seen within a short space of time on the same day. Trust figures show that 92% of referrals are seen within 24 hours.
- In total in 2015/16 there had been a total of 2,259 referrals to the specialist palliative care teams across both Worcestershire Royal and Alexandra hospitals. Of those, 49% were for patients with a cancer diagnosis and 46% were for patients with a non-cancer diagnosis and 5% were unclassified.
- The specialist palliative care team worked closely with emergency department staff to explore patient flow through the department. This work had commenced following comments from relatives regarding waiting times and the capacity constraints of emergency department staff when a patient at the end of life accesses the services. This included specialist palliative care nurses proactively engaging with emergency department staff on a daily basis to raise awareness of the support they could offer and to help identify patients who may benefit from their input. This work sat within an overall aim to improve access and flow for patients through the emergency department and support patients at the end of life being cared for in their preferred place.
- In addition, staff we spoke with in the emergency department told us they would often access the specialist palliative care team to provide support for patients at the end of life who had come from nursing homes. This included times when the nursing staff in the home needed more support to care for the person in their usual place of residence rather than them needing a hospital admission. The trust had audited preferred place of care at the end of life in 2016 as part of an ongoing audit process. They had identified that 74% of patients had no preference documented in their records. Of those that did, 62% had achieved their preferred place of care at the end of life. As a result of this audit the specialist palliative care team had added preferred place of care to their patient record system so that monitoring of this could lead to improvements over time.

Learning from complaints and concerns

- Information was available for patients on how to complain or feedback about the service experienced. People were signposted to the Patient Advice and Liaison Service (PALS) where concerns were unable to be resolved at ward level.
- A complaints audit carried out in March 2016 explored nine complaints from Worcestershire Royal Hospital that had an end of life care component. More than 50% of these had an element of poor communication or attitude that contributed to the complaint. As a result the specialist palliative care team had added a focus of communication skills to their training, including advanced communication skills for non-specialist staff and sessions on how to demonstrate a caring attitude when under pressure.
- The lead nurse of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.
- Minutes of monthly palliative care team meetings demonstrated that complaints relating to end of life care were discussed with a view to learning lessons and making improvements.
- Feedback from bereaved relatives included concerns raised about the length of time it took to process death certificates. Action was being taken to resolve this and we viewed minutes of a privacy, dignity and bereavement group meeting where this had been discussed and formed part of an action plan to improve services.

End of life care

Are end of life care services well-led?

Good

We rated well-led as good because:

- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.
- There was consistent promotion of the delivery of high quality person centred care and several audits had been undertaken to evaluate the service. There were clear and timely action plans in place to address improvements identified.
- There was strong leadership from the specialist palliative care team and from ward based nursing staff and trust wide leadership from the chief nurse and non-executive leadership at board level.
- Staff were consistently passionate about end of life care, positive about their roles and consistent in their belief that the quality of end of life care was good.
- A range of meetings took place across the trust and the locality with representation from the specialist palliative care team where the planning and development of end of life care services was discussed. There were also clear reporting structures across the directorate and the trust as a whole.
- A number of innovations were apparent with a focus on improving end of life care across the trust.

Vision and strategy for this service

- The trust were working with other end of life care services within the locality to develop an end of life care strategy. There was a clear vision for end of life care that included people receiving individualised and coordinated care. In addition, there were defined objectives relating to specialist and non-specialist services, county wide and trust wide activities.
- Members of the specialist palliative care team participated in county wide network activities, ensuring the trust was involved in strategic discussions about end of life care.
- Minutes of meetings demonstrated that strategic and developmental activities relating to end of life care were high on the agenda, including in the trust wide 'high impact action group' meetings for end of life care. Information is disseminated to staff through the end of life care champions and end of life care facilitators working on the wards.
- The chief nurse was the executive lead for end of life care across the trust. In addition there was a non-executive director lead for end of life care. There was a clear reporting structure for end of life care within the trust and evidence of end of life care discussions at board level.

Governance, risk management and quality measurement

- Specialist palliative care reports within the specialised clinical services division of the trust with governance systems in place to ensure effective reporting, learning and improvements to end of life care across the trust.
- In the previous inspection it was identified that the trust did not have a palliative/end of life care risk register. This had since been developed with issues such as the supply and flow of syringe drivers identified as a potential area of risk. As a result, action had been taken to improve the availability and flow of syringe drivers so that they were available when patients needed them.
- Regular meetings were held where issues of governance were discussed including monthly team meetings and weekly multidisciplinary meetings.
- Audit was used to monitor the quality of service and inform improvements to practice. Examples we viewed included do not attempt cardiopulmonary resuscitation (DNACPR) audits, significant event and complaint audits, AMBER care bundle audits and the trust participation in the National Care of the Dying audit (NCDAH).
- Staff were involved in sharing lessons and improving practice across the service, including specialist staff and ward based end of life care champions.

Leadership of service

- There was clear leadership in end of life care across the trust. The senior consultant in palliative medicine was the clinical lead and together with the nursing lead for palliative care worked to develop the service to meet the needs of patients.

End of life care

- Members of the specialist palliative care team, including the end of life care facilitator were enthusiastic and motivated to share practice and develop ward and clinical based services across the trust to better meet the needs of patients at the end of life.
- There was good local leadership at ward based level with end of life care being seen with an appropriate level of priority. End of life care ward champions were available on every ward, generally with more than one for each area to ensure a good level of additional skill and support available.
- There was a clear commitment to quality end of life care across wards within the hospital and we saw ward managers and staff alike focused on improving and developing end of life care in general ward settings.

Culture within the service

- Staff were consistently positive about delivering quality care for patients at the end of life and told us they felt supported to deliver good end of life care.
- Staff were proud of their work around end of life care. The specialist palliative care, bereavement, chaplaincy and mortuary staff demonstrated an enthusiasm and passion for continuously improving services to meet the needs of patients and families.

Public and Staff engagement

- Bereavement surveys were sent out to relatives of patients who had received end of life care within the trust. There was clear evidence that the results of these surveys influenced the development of the service with action taken to address issues of concern. For example, in relation to the flow of end of life care patients through the emergency department.
- The trust participated in activities to raise awareness and hold discussions with the public on death and dying during 'dying matters' week each year.
- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to. For example, staff were able to feedback to management during 'listening in action' sessions where issues that impacted on patient care were discussed. These meetings had resulted in action taken to improve facilities in the hospital for families of patients at the end of life such as the provision of showering facilities.
- Specialist palliative care staff and end of life care champions attended regular team meetings where they had the opportunity to input into the development of the service.

Innovation, improvement and sustainability

- There were a number of innovations relating to care for patients at the end of life. This included the work of the specialist palliative care team in working proactively with the emergency department to raise awareness and promptly address issues relating to symptom management or end of life care for patients in the emergency department.
- There was a strong audit culture within the specialist palliative care team where areas for improvement were identified and clear action taken to address these. For example, in relation to the use of the VOICES bereavement questionnaire for bereaved relatives and regular audits of the AMBER care bundle and the Optimising End of Life Care Plan records.
- The specialist palliative care team Building on the Best quality improvement partnership project with The National Council for Palliative Care and Macmillan Cancer Support for acute hospitals demonstrated a commitment to continued improvement to end of life care services. The trust was one of 10 that had been selected to participate in the project. The team had in place a clear plan to involve generalist staff in the project and to create care improvements for patients at the end of life who were being cared for at ward level. The team had undertaken scoping exercises to flesh out the project and had focus groups planned for early 2017 to involve key staff in further defining and implementing the project. The plan was to pilot the initiative in one ward at Alexandra Hospital and one ward at Worcestershire Royal Hospital.
- The lead consultant in palliative medicine was involved in discussions as part of end of life care related mortality reviews. This enabled them to have an input into improving end of life care as part of this process.

Outpatients and diagnostic imaging

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

Information about the service

Worcestershire Acute Hospitals NHS Trust was established on 1 April 2000 to cover all acute services in Worcestershire with 877 beds. It provides a wide range of services to a population of around 580,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

Worcestershire Acute Hospitals NHS Trust provides services from four sites: Worcestershire Royal Hospital, Alexandra Hospital, Redditch, Kidderminster Hospital and Treatment Centre and surgical services at Evesham Community Hospital, which is run by Worcestershire Health and Care NHS Trust. 5,904 whole time equivalent (WTE) staff are employed across the trust.

Radiology services provided by the trust are located at three sites: Worcestershire Royal Hospital, Alexandra Hospital, Redditch, and Kidderminster Hospital and Treatment Centre. The service is managed by one management team based at Worcestershire Royal Hospital. Information technology systems (IT) that support the radiology services across all three sites are provided at the Worcestershire Royal Hospital site.

The outpatient and diagnostic imaging service is under the specialised clinical services division. The current structure includes a divisional operational manager, divisional director of nursing and divisional medical director. This team is supported by a deputy divisional operational manager, deputy divisional director of nursing and deputy divisional medical director, plus a directorate manager and matron.

Outpatients includes all areas where people undergo physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case.

Outpatient clinics were held in the Sorrel, Hawthorn, Mulberry, Redwood, Linden, Larkspur and Rowan suites and Aconbury west. The Sorrell suite was located on the ground floor of Worcestershire Royal Hospital. Hawthorn, Mulberry, Redwood, Linden, Larkspur and Rowan suites were located on the first floor of Worcestershire Royal Hospital. Aconbury west was in a separate building towards the back of the Worcestershire Royal Hospital site.

Radiology procedures that are undertaken at Worcestershire Royal Hospital include: computed tomography (CT) scans, magnetic resonance imaging (MRI), obstetric ultrasounds, general ultrasounds, nuclear medicine studies, plain film x-ray, mammography, angiography, fluoroscopy,

dual energy x-ray absorptiometry (DXA) and symptomatic and screening mammography. The trust had 748,073 first and follow up outpatient appointments from April 2015 and March 2016.

Worcestershire Royal Hospital's total number of outpatient appointments was 374,775.

We carried out an announced inspection at Worcestershire Acute Hospitals NHS Trust from 22 November to 25 November 2016. We visited a number of the outpatient clinics, including Sorrel, Hawthorn, Mulberry, Redwood,

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Linden, Larkspur and Rowan suites and Aconbury west. We visited diagnostic services, including radiology, cardiology, dermatology, trauma and orthopaedics, ophthalmology and diabetes.

We spoke with 24 patients, their relatives, and 60 staff, including consultants, radiographers, radiologists, nurses, healthcare assistants, allied health professionals, reception staff and medical secretaries. We also reviewed the trust's performance data.

Some of the performance data is only available trust wide and relates to all hospital sites covered by the trust. Performance data regarding the Worcestershire Royal Hospital only has been used where available.

Summary of findings

Overall, we rated the outpatients and diagnostic imaging services as inadequate.

We rated inadequate for responsive, safe and well led, and good for caring. CQC do not have the methodology to rate the effective domain. The service was judged to be inadequate overall because:

- There was a lack of radiation protection infrastructure.
- There was inadequate review and document control of protocols for standard x-ray examinations. Some protocols were in a handwritten format with alterations made by various members of staff without apparent ratification.
- Aging and unsafe equipment across the trust that was being inadequately risk rated with a lack of capital rolling replacement programmes in place.
- There have been two patient safety incidents in the trust whereby patients had been physically injured by unsafe x-ray equipment.
- Whilst staff were aware of their roles and responsibilities with regards to reporting patient safety incidents, incidents reporting in outpatients was low and where incidents had been reported, the dissemination of lessons learnt was insufficiently robust.
- The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care.
- There were medical vacancies across all specialities. This meant there could be a delay in patients being seen for new or follow-up appointments.
- The compliance rate for safeguarding children level two training for medical and dental staff within the specialised clinical services division (which included outpatients, ophthalmology, rheumatology and radiology) was 33%.
- Staff we spoke with were unable to confirm harm reviews were in place for the patients who had waited over 18 weeks for an appointment.

However we also found:

Outpatients and diagnostic imaging

- Staff were dedicated and caring. Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support.
- The premises were visibly clean.
- The process for keeping patients informed when clinics overran was established and well managed.
- There were effective systems in place regarding the handling of medicines.
- Patients could be referred to specialist pain clinics held at the Worcestershire Royal Hospital, Kidderminster Treatment Centre or clinics held at local community hospital sites. Four anaesthetic consultants with experience in advanced pain medicine led the pain management service. This is in line with the Royal College of Anaesthetists recommendations.
- Leadership within the outpatient's team was visible however, the management of risk was insufficiently robust and further improvements were necessary.

Are outpatient and diagnostic imaging services safe?

Inadequate

Overall, we rated the outpatient and diagnostic imaging service as inadequate for safe because:

- We were not assured patients were always protected from harm, as not all staff were confident to report incidents.
- There was a shortage of medical vacancies across all specialities. This meant there could be a delay in patients being seen for new or follow-up appointments.
- Safety was not a sufficient priority with regards to replacement of aging and potentially unsafe x-ray equipment across the Trust. There is no robust capital replacement programme within radiology with medical devices on the risk register being downgraded with no consultation with the radiology lead senior manager.
- Standard operating procedures within radiology were not adequately reviewed and were not subject to robust document control. Examination protocols including medical exposure parameters were insufficiently revised.
- Staffing levels of radiologists were inadequate for the demands of the service. The lack of specialised radiologists in interventional radiology did not allow for a 24-hour service for patients requiring interventional procedures out of hours.
- The compliance rate for safeguarding children level two training for medical and dental staff within the specialised clinical services division (which included outpatients, ophthalmology, rheumatology and radiology) was only 33%.
- Staff we spoke with were unable to confirm harm reviews were in place for the patients who had waited over 18 weeks for an appointment.

However we found:

- Most equipment was checked regularly and maintained by a third party.
- All areas we inspected, including clinical and waiting areas, were visibly clean and tidy.
- Generally, the design, maintenance and use of facilities and premises met patients' needs.

- There were effective systems in place regarding the handling of medicines.
- Patients' medical records were accurate, complete, legible, up to date and stored securely.
- Outpatients nurse staffing levels and skill mix was planned and reviewed so that people received safe care and treatment.

Incidents: Outpatients

- We were not assured patients were always protected from harm, as not all staff were confident to report incidents. At the last inspection, in July 2015 we saw there was a view that staff would not routinely report common issues, especially if there was a view that the issue would remain unresolved. We did not see an improvement on reporting of incidents on this inspection.
- There were limited arrangements in place to implement good practice for incident reporting. There was an electronic reporting system in place to report incidents. Staff were aware of the system and how to use it to report an incident. However, staff were not able to identify what incidents should be reported.
- Worcestershire Royal Hospital outpatients and diagnostics department reported 155 incidents from 1 September 2015 to 31 August 2016. Incidents were graded in severity from low to no harm, or moderate to severe harm. Six were graded as moderate harm, 79 were graded as minor harm and 106 were graded as no harm. At the last inspection, the number of incidents reported within the outpatient department was reported to be exceptionally low. On the current inspection the outpatients leads were asked about incident reporting they identified that only the incidents relating to the environment and specifically about nursing staff in the department were identified as reportable within the outpatients department. Incidents were also reported by specialty. There was a risk information about incidents that had occurred within the department was not accessible to outpatients staff.
- The trust did not report any incidents, which were classified as never events for outpatients from October 2015 to September 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in Outpatients, which met the reporting criteria set by NHS England from October 2015 and September 2016. Two were reported at Worcestershire Royal Hospital
  - Adverse media coverage or public concern about the organisation or wider NHS.
  - Radiation incident (including exposure when scanning) meeting SI criteria. Staff we spoke with were aware of the incidents. Investigations had been completed and there were action plans in place to mitigate further risks.
- At the last inspection, we found the approach to learning from incidents was varied, depending on the grade and health profession of staff that we spoke with. On the recent inspection, we found learning from incidents was still variable. Some staff we spoke to were able to describe examples of learning from incidents within their speciality. We saw some evidence in team meeting minutes of discussions about learning about incidents. However, there was insufficient evidence in team meeting minutes to confirm that learning from incidents was shared across all the departments within the outpatient department.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour was a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident.
- When things went wrong, thorough and robust reviews or investigations were carried out. We reviewed the investigation of a serious incident and saw they had been managed in line with the duty of candour regulation. We saw process and evidence of written apologies. We saw relevant staff and people who used services were involved in the review or investigation.

- All incidents, which were reported as resulting in severe harm or death, generated an automated email to the patient safety team and divisional staff, who then allocated the serious incident to an appropriate clinician or senior member of staff to investigate. We reviewed the root cause analyses of two serious investigations related to the outpatients department. We saw root cause analyses had been completed and included recognition of care and, contributory factors, lessons learned and actions to be completed to reduce the risk of further incidents. We also saw evidence that patients were informed and the duty of candour was followed, where appropriate. The investigations that we reviewed demonstrated that the majority of actions identified to minimise the risk of further incidents were completed. Staff were able to give us examples of lessons that had been learnt from incidents and we observed that lessons learnt were shared across relevant departments.
- There was evidence of lessons learned, and action taken as a result of investigations. We saw evidence in team meeting minutes of shared learning and a review of ways of working had been reviewed to minimise the risk of similar incidents reoccurring.

Incidents: Diagnostic imaging services

- Staff were aware of how to report an incident and team leaders were aware of reportable thresholds for radiation incidents.
- The trust did not report any incidents, which were classified as never events for diagnostic imaging services from October 2015 to September 2016.
- There had been four reportable incidents from diagnostic imaging services across the trust to the Care Quality Commission (CQC) as required under the ionising radiation regulations 2000 (IRMER), in the last 12 months. These incidents were categorised as low risk medical exposures, which had not resulted in serious harm to patients and all have been subject to investigation through local governance arrangements. A number of notifications remain open with us and were sent through to us following on from the inspection. The CQC IR(ME)R inspection team who oversee these notifications had undertaken extensive investigation into each of these incidents and were assured the trust had carried out necessary actions.
- The imaging department had reported 162 incidents from August 2015 to August 2016 across all imaging modalities. These incidents covered a wide range of near misses and minor harm to patients. 58 incidents related to delayed reporting of images, three cited an incorrect initial report, which delayed treatment, and 31 incidents were recorded due to two-week wait referrals being prioritised and booked as routine appointments.
- There was one concern whereby a paediatric trauma patient had been scanned in CT using an adult protocol because there were no site-specific paediatric trauma guidelines. This was due to low numbers of paediatric patients who were generally admitted to other regional trusts. This incident occurred due to the emergency department employing a locum consultant who was unaware of paediatric requirements locally. The incident had been formally investigated and changes had been made as a result. The emergency department had changed the protocols and induction for locum staff. The radiology service had adopted some paediatric protocols. The gold standard was not to image children at this site and emergency department staff managed this.
- Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. We saw posters for staff on the topic of duty of candour.
- When things went wrong, thorough and robust reviews or investigations were carried out.
- The medical physics service were consulted about diagnostic imaging services incidents in order to provide a dose assessment, however they were rarely recorded on the investigation or review of the incident.
- There was evidence of lessons learnt, and action taken as a result of investigations. There was a dedicated area on poster boards for clinical governance information. Displayed on this was information about the incidents and learning points for radiographers to view. Staff were aware of the learning from incidents.

Radiation Protection

- The department had a full set of Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R procedures and standard operating procedures as required under the Regulations.
- The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 1999 (IRR99). Local rules as required under IRR99 were evidenced throughout the

department. All areas that utilise medical radiation in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff.

- We observed that the ophthalmology department had produced 'local rules' for the use of laser equipment, which were designed to minimise the risk of harmful exposure to laser radiation to staff, patients and members of the public.
- Radiation protection services were supplied by an external radiological protection service and were employed by the trust on 1 April 2016. The company were responsible for the provision of a radiation protection advisor, medical physics expert, radiation waste advisor and magnetic safety advisor. Prior to this date, the service provision was through another third party provider.
- The last radiation protection advisor (RPA) audit was carried out in July 2016. Discussion with the medical physics service described a detailed RPA audit process they have undertaken since commencing service to the trust. A number of recommendations had been made by the medical physics service. It was cited during the inspection that due to staffing, pressures of the clinical workload, finances and lack of training opportunities very few of the recommendations had been carried out.
  - The trust overall were identified as having a lack of radiation protection supervisors as required under IRR99. There needed to be up date training and associated training records to be held. The service provider had offered to provide this training but at the time of the inspection, this had not been actioned.
  - There was no written process for additional engagement required of the physics service and it was stated that this was led by service engineer reports and comments and not driven by trust's procedures.
  - There were no apparent criteria for staff locally to follow after a service engineer had undertaken routine or unplanned maintenance or repair of equipment. Although handover documents were seen there was no trigger for the involvement of medical physics following these visits which was often required if changes that affect patient dose were made to the equipment.
  - At the start of the contract, there was a meeting to discuss the new ways of work. There was no action plan formulated around areas the trust was particularly concerned about.
- The IR(ME)R guidance for all diagnostic exposures suggests a medical physics expert (MPE) should be consulted as part of a robust optimisation programme and providing advice relating to matters of radiation protection. There were limited opportunities for liaison between the (MPE) and radiation protection advisor. There was no set timeframes around how often radiation protection advisors and medical physics experts should meet or correspond with the trust.
- The radiation protection committee meeting was held annually. This was the only formal meeting scheduled as part of the service level agreement with the private radiological protection service. The next annual meeting was due to be held in December 2016.
- The local rules specified there were only three radiation protection supervisors (RPS) to cover Worcestershire Royal hospital and the three satellite sites, one of which was appointed in November 2016. A RPS role is required under the ionising radiation regulations 1999. This role is to ensure that the area they are assigned to supervise has a locally reflective set of local rules and ensure all staff working in the area read, understand and abide by the rules. A RPS should be appointed for an area that they work in to ensure that staff were abiding by the local rules. Due to the lack of RPS' some areas where radiation was used did not have a suitably trained member of staff to oversee radiation protection in that area.
- Not all policies were reviewed in a timely way. The radiation safety policy was due for revision in July 2016, however we were told that this was currently waiting sign off at the next radiation protection committee in December 2016.
- A list of authorised MRI personnel was evidenced in the departmental local rules but these did not accurately reflect the displayed list. Therefore, there was no clear identification of job roles and persons who were able to supervise and control staff and patients/carers into an area with a high magnetic field.
- The scan room keys for MRI were not stored securely during the working day; these were stored in a tin on a shelf in the control room, which was accessed, by not

only staff in radiology but also staff from elsewhere in the hospital. There was a risk unauthorised persons would be able to access the room unsupervised. This was raise with senior staff at the time of the inspection.
- We were not assured risk assessments were up to date. The nuclear medicine department risk assessments were contained as an appendix to the departmental local rules. They had not been reviewed by the new medical physics provider.
- Controlled area signage throughout the department was poor and did not demonstrate a consistent format or the correct word diagram or pictograms. There was a risk to staff and patients who may not be aware of the risk of entering the environment when x-rays were being used. There was a very small chance that they may be exposed to a small amount of radiation.
- Optimisation, which is the process of ensuring that the patient receives the lowest possible dose of radiation to produce a diagnostic image, of medical exposures was not reviewed regularly. This is a requirement of IR(ME)R, while timescales are not regulation but was a requirement to regularly review does, image quality and training. According to guidance and notes on good practice, this is generally deemed appropriate at three yearly intervals. The service reviewed the optimisation of medical exposures at the annual radiation protection committee, this was the only forum whereby optimisation was discussed between the trust and the medical physics service. Optimisation of medical exposures was a requirement under IR(ME)R to ensure patient doses were kept as low as reasonably practicable.
- Dose audits, which are required under IR(ME)R to ensure doses are kept as low as possible, were undertaken periodically however staff told us they were not carried out regularly or robustly, this was predominantly due to staffing levels. We were informed by senior radiographers that staffing was an issue in so far as they did not have enough staff availability to collect and collate the data to send to the medical physics experts to interpret.
- The department had highlighted they needed more guidance and assistance from the medical physics provider but in the absence of radiation protection governance structure it was felt this was difficult to coordinate.

Cleanliness, infection control and hygiene: Out patients

- All areas we inspected, including clinical and waiting areas, were visibly clean and tidy. We saw completed cleaning schedules in place, which confirmed areas had been cleaned. Patients we spoke with told us they did not have any concerns about cleanliness of the department. However, we did see in a clinic room in the sorrel outpatient unit, one set of curtains that were not dated so the staff were unsure when they would need to be replaced. This was raised at the time of the inspection and staff ensured these were replaced.
- Staff told us that nursing staff cleaned equipment daily. The environment was cleaned daily an external provider, who cleaned the department in the evening. We saw the service level agreement for the provision of housekeeping services, which included daily, weekly and monthly cleaning schedules. Housekeeping staff cleaned the consultation and treatment rooms daily. Any issues regarding the cleanliness of the outpatients department were reported to the external provider via a helpdesk. Compliance against schedules was through an audit system. The results of which were signed off by the housekeeping supervisor and a clinical representative from each area.
- Toilets were clean and were equipped with hand washing sinks, hand washing gels and paper towels.
- Staff complied with infection prevention and control policies. Clinical staff adhered to the provider's 'arms bare below the elbow' policy to enable good hand washing and reduce the risk of infection. We observed staff wash their hands immediately before and after every episode of direct contact or care and use personal protective equipment (PPE), such as gloves and aprons. There was access to hand washing facilities and a supply of PPE.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. We saw posters in waiting areas and other communal areas advising patients and visitors to use hand gel dispensers.
- We inspected 26 consulting rooms and noted all had gloves, aprons and hand washing facilities available.

- We saw all clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. All sharps boxes were clean, were not overfilled and had temporary closures in place to minimise the risk of needle stick injuries.
- Precautions were taken in the outpatients department when seeing people with suspected communicable diseases such as flu. Appointments were usually booked at the end of clinic, patients were taken straight to the clinic room without the need to wait in the waiting room. We saw cleaning scheduled that demonstrated and staff told us the room had a thorough deep clean before being used again. Cleaning schedules were up to date and complete.
- Trust data for July 2016 showed completed infection control and hand hygiene training met the trust target of 90% compliance; 92% of staff had completed infection control training and 100% of staff had completed hand hygiene training. Therefore, we were assured that staff had completed appropriate training and had up-to-date knowledge of infection control and prevention measures in order to protect patients, visitors and staff from potential harm.
- We saw evidence of monthly hand hygiene audits that demonstrated a good standard of hand hygiene being maintained in the outpatients department. The audit included whether staff were 'arms bare below the elbow' and if they washed their hands before and after each patient contact. From May 2016 to October 2016, compliance in the outpatient department was 100%. This was an improvement from the previous inspection, where we saw little evidence of auditing of hand hygiene.
- The outpatient department participated in the Saving Lives audit, designed to ensure effective prevention and control of healthcare associated infections. This is in accordance with national recommendations (Department of Health, Saving Lives: reducing infection, delivering clean and safe care, 2007). From April 2017 to January 2017, compliance in the outpatient, ophthalmology and audiology department was 100%.
- The outpatient department had one infection control and hand hygiene link nurse who attended infection prevention and control link nurse study days and cascaded information to members of the team. An infection control folder was available for staff to use as a resource, which contained up-to-date infection prevention and control guidance. We reviewed this during our inspection. Staff also had access to infection control policies via the trust intranet.
- As of December 2016, 41% of staff within the outpatient department had been vaccinated against influenza. Public Health England recommends that all frontline staff are vaccinated annually in order to reduce the risk of catching and/or spreading influenza.

Cleanliness, infection control and hygiene: Diagnostic imaging services

- Compliance against local targets for cleanliness of the environment including general wear and tear was 94% against a 100% target. There was a specific concern around uncovered foam immobilisation pads in the x-ray rooms. These had been identified as an infection control risk. The team had received advice to manage the situation from the infection control team and an action plan was in place.
- Not all areas we inspected were visibly clean. There was high-level dust particularly on curtain poles and on picture frames within the waiting areas in diagnostic imaging services. We saw cleaning schedules were available but were not always consistently completed therefore we were not assured the area had been regularly cleaned. We did evidence cleaning schedules being used, but they were not always consistently completed.
- There were three infection control links staff in the department. They supported infection control education of departmental staff.
- Hand hygiene audits was scheduled to be undertaken weekly however we only saw evidence of two audits carried out in November 2017 where compliance was 89%. We only received this data post inspection and so we are unsure of any action plans.
- There were concerns that ultrasound intra-cavity probes were not being cleaned sufficiently. After speaking with the ultrasound lead, we were informed there had been conflicting advice from the infection control team as to the cleaning process. A cleaning agent was currently being used and the use of a disinfectant cabinet was being investigated.

Environment and equipment: Outpatients

- Generally, the design, maintenance and use of facilities and premises met patients' needs. However, the seating

arrangements within the outpatient department were not always fit for purpose. Many of the chairs within the department were low to the ground and did not have arms or supports meaning some patients experienced difficulties both sitting and standing from the chairs. Additional chairs with higher seats and arms had been brought into the department, but usually one per clinic, so if more than one patient with reduced mobility, such as difficulty standing from a low chair were in clinic they would have to sit on a chair not suitable for their needs or stand.

- Adult and paediatric emergency equipment, such as defibrillator (device that gives a high-energy electric shock to the heart through the chest wall to someone who is in cardiac arrest), oxygen and suction, were available in the outpatient department for use at short notice. The equipment was checked on the day's the outpatient department was open to ensure it was in working order. We reviewed completed checklists from 17 October 2016 and 23 November 2016 we saw all equipment had been checked daily. Therefore, we were assured there was a reliable system in place to ensure emergency equipment was checked in line with trust policy. The oxygen cylinders and emergency medicines were all in-date.
- Clear signage and safety warnings were in place outside the clinic room where ophthalmic lasers were used. This room was observed to be locked when not in use.
- Arrangements for managing waste and clinical specimens were in line with policies. Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Bins were not overfilled.
- We could not ensure that all equipment was suitable for purpose. The maintenance of equipment was completed via a service level agreement with the manufacturer or the trust's estates department. A schedule of work was in place and equipment was assessed annually as safe for use. We saw evidence of maintenance checks for equipment in most clinic areas. However, there was evidence that equipment had not been checked in all outpatient departments, such as in the oral surgery clinic where maxillofacial orthodontics clinic were being carried out we saw the diathermy machine and the machine to check anticoagulation had last been tested in 2012 and the pressure testing machine had last been tested in January 2015. Anticoagulants are used to treat and prevent blood clots that may occur in your blood vessels. Blood clots can block blood vessels (an artery or a vein). A blocked artery stops blood and oxygen from getting to a part of your body (for example, to a part of the heart, brain or lungs). The tissue supplied by a blocked artery becomes damaged, or dies, and this results in serious problems such as a stroke or heart attack. Some patients are required to have their anticoagulant blood levels tested daily. We informed the sister at the time of inspection, the equipment was taken out of action and the sister highlighted the need for the equipment to be checked.

Environment and equipment: Diagnostic imaging services

- We saw an inventory of equipment, there was no formal capital rolling replacement programme for some of the aging equipment across the trust. This was on the service's risk register.
- We saw evidence of quality assurance (QA) reports from the radiological protection service and handover documents for equipment testing and commissioning across all imaging modalities.
- Personal protective equipment was available, clean and well stored and subject to routine screening.
- QA testing undertaken by radiographers was carried out at the hospital but it was identified by the medical physics service that this was not being undertaken frequently enough and that there were a lack of trained members of staff to undertake the activity. The Institute of Physics and Medical Engineering (IPEM), publish standards and various checks need to be undertaken on equipment daily, weekly, monthly or quarterly depending on the specific check. QA was sporadic and some records showed a consistency against the standard but not all. The consequence of this is that equipment over time may deteriorate or need minor adjustments to components. If QA is not carried out then image quality and patient doses can be affected.
- Resuscitation trolleys were checked, we found occasions where checks had not been completed and documented to ensure the equipment was fit for use. The results of a six-month audit carried out in August 2016 identified three days where the resuscitation trolley in computed tomography (CT) area had not been checked. Staff cited that there had been a lapse in these checks being undertaken and following discussion at staff meetings this had been addressed, there were no

subsequent gaps in the checklist. However, we found evidence that regular checks had been completed and documented to ensure the two MRI compatible resuscitation trolleys in the department were fit for use.

- The nuclear medicine gamma camera despite its age was cited as being reliable and resilient with little downtime. The equipment service that managed this piece of equipment was responsive when required. The equipment was reliable but due to its age could deteriorate and should be on a capital replacement programme to ensure service continuity.
- We saw an inventory of equipment, which was a requirement under IR(ME)R.
- Refurbishment of a previous radio pharmacy area for the purpose of dispensing was underway. Current practice of using a desktop cabinet for sub-dispensing, within the patient injection room was sub-optimal because it was in the patient injection room and should be undertaken in the radio pharmacy for radiation protection purposes.
- There was limited evidence of environmental monitoring for areas where ionising radiation was used, we did not see the evidence of any audits. Some of the monitors were from the previous radiation protection service and therefore had not been analysed.
- There was no clear indication of radiation doses to controlled areas.
- The risks included, which would affect staff, and members of the public.
- The cross sectional control was a very noisy environment with constant distractions; this has been raised on numerous occasions, as staff were fearful of mistakes being made due to constant disruptions. At the time of inspection, there were no plans to address this.

Medicines: Outpatients

- There were effective systems in place regarding the handling of medicines. Outpatient staff had some medicines available within the clinic areas and could access specific medicines from pharmacy, if necessary. Nursing staff we spoke with were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management.
- There was an established system for the management and storage of medicines to ensure they were safe to use. Medicines that needed to be kept below a certain temperature were stored in designated refrigerators in outpatient departments.
- There were arrangements in place to ensure safety of controlled drugs and chemotherapy. Staff were aware of the arrangements. Staff were aware and adhered to the trust's medicine policy medicines policy (Policy on the Purchasing, Prescribing, Supply, Storage, Administration and Control of Medicines).
- Staff checked the ambient room temperatures and fridge temperatures, theses checks were carried out in line with trust policies and procedures. The temperature records we reviewed for October 2016 and November 2016 were completed and contained minimum and maximum fridge temperatures, which alerted staff when they were not within the required range. Staff we spoke to were aware of the procedure to follow when temperatures were not within the required range.
- FP10 prescription pads were stored securely. FP10 prescriptions are the common form used as a prescription. They are used for outpatients, and can be taken to any pharmacy and filled. We saw that monitoring systems were in place to ensure that all prescriptions were accounted for. At the previous inspection, we found that three FP10 pads were unaccounted for. We raised our concerns with the hospital pharmacist and matron for outpatients who took immediate remedial action to resolve the issue and to locate the missing pads. Since the last inspection, pharmacy had instigated a new checklist form. On the current inspection, we saw all FP10 pads were present and correct and had been signed. All stock FP10 pads were stored in locked cupboards.
- Patient group directives (PGDs) were used in the ophthalmology service to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. We saw that these had been authorised and signed appropriately.
- The trust wide electronic incident reporting system was used to report medicine incidents.

Outpatients and diagnostic imaging

Medicines: Diagnostic imaging services

- The administration of contrast intravenous fluid used in MRI and CT to highlight organs and vessels was cited as being via patient group directives (PGD). However, at the time of the inspection staff in MRI could not locate these PGDs. In computed tomography (CT) PGDs were evidenced for all staff.
- In nuclear medicine, administration of radioactive substances advisory committees (ARSAC) were used and diagnostic reference level charts were signed by the ARSAC holder. A limited number of paediatric examinations were undertaken, documents were evidenced which referred to explicit pages in ARSAC guidance for dose adjustment for children.
- The medicines used in the diagnostic imaging department were well managed. The drugs were all stored safely, and regularly checked for use by dates. We witnessed a drug check at the time of the inspection. Medication was kept in locked cupboards, with the exception of the contrast media, which was stored appropriately and which was only accessible by key members of staff. Temperatures were regularly recorded for both the fridge and the storage cupboard.
- The imaging department had a good process in place for prescribing bowel preparation medication used for CT colonograms (graphic recording of movements of the colon). Patients would attend the department to collect the medication, radiographers were able to discuss how to take the medication and discuss the test itself. This process was well recorded of the radiology information system and in manual logs to track the medication.

Records: Outpatients

- Patients care records we reviewed accurate, complete, legible, up to date and stored securely out of reach and view of patients.
- Records were available for clinic appointments. Our review of 25 records, including referral letters, information about procedures undertaken and results of investigations and discussion with staff confirmed, since electronic notes had been introduced, no concerns about records not being available had been raised. The trust monitored the availability of electronic case notes for every patient attendance. The outsourced health records service provider captured the date and time of the attendance and the date and time of the scanned notes being available in order to ensure the outsourced health records service provider met the agreed scan service level agreements.
- From February 2016 and September 2016, the trust reported 0.28% of patients seen in outpatients without their full medical record being available. Whilst this was within the agreed service level agreement, the trust reported they mitigated this by accessing the clinical letter system and the clinical results system. If further information was needed, they contacted the GP for copies of clinical information.
- Staff told us now that records were electronic, unavailability was exceptionally rare. They told us and we saw if the patient had an urgent post admission appointment, the ward clerks and outsourced health records service provider used the “priority scan” process to ensure notes were available in time. The outsourced health records service provider managed the medical notes service for the trust. Information received from the trust prior to inspection stated that the external provider followed a missing notes process if patient records were not found immediately. We requested a copy of this but were told the trust did not have a formal process in place for missing patient records. We were told that the trust planned to have a formal process in place by the end of March 2017.

Records: Diagnostic imaging services

- Patients care records we reviewed accurate, complete, legible and up to date.
- In ultrasound we saw a door left open with the radiology information system showing a patients record in full view of the waiting area. We raised this with staff at the time of the inspection and the issue was addressed.
- Patients’ radiological images and records were stored securely and access was password protected. The imaging department used a radiology information system (RIS) and picture archiving and communication system (PACS).
- We saw evidence of pregnancy checks and MRI safety checklists and that these were stored against the patients’ records.

Safeguarding: Outpatients

Outpatients and diagnostic imaging

- Policies were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Staff were required to complete safeguarding adults and children training on trust induction, following commencement of employment, and refresher training every three years. Refresher safeguarding training was completed via e-learning modules, with some ad hoc sessions provided for safeguarding children training. The safeguarding children e-learning module was developed in collaboration with experts from six safeguarding children boards and had been updated to include female genital mutilation, radicalisation, forced marriage, child trafficking and child sexual exploitation.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures. In July 2016, 89% of Worcestershire Royal Hospital outpatient's staff had attended safe child training, which was slightly below the 90% target set by the Clinical Commissioning Group (CCG). However, the compliance rate for safeguarding children level two training for medical and dental staff within the specialised clinical services division (which included outpatients, ophthalmology, rheumatology and radiology) was only 33%. All Worcestershire Royal Hospital outpatient's staff and 97% of medical and dental staff within the specialised clinical services division had attended safe adult training. Therefore, we were not assured that all outpatient, medical and dental staff had up to date knowledge in order to protect children from potential harm. We saw no evidence that any action had been taken to address non-compliance with safeguarding children training. We reported that the trust must ensure all staff were compliant with the trust target for safeguarding children training as a priority, in our previous report.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns. Information and relevant contact numbers for safeguarding were seen in outpatient clinic areas and public areas. Staff were aware of safeguarding procedures and knew how to escalate concerns.

Safeguarding: **Diagnostic imaging services**

- Not all radiology staff were compliant with safeguarding training.
- We saw 89% of radiology staffing and 90% of medical staff had received child safeguarding level 2 training. We did not see any records relating to level 3 safeguarding training.
- We saw 96% radiology staff and 93% of medical staff were compliant with level 2 adult safeguarding training.
- We saw 'paused and checked' posters displayed in all imaging areas visited. The Society and College of Radiographers produced this resource to reduce the number of radiation incidents occurring within radiology departments. 'Paused and checked' is a prompt to ensure safety checks are carried out on each patient before and after an exposure to radiation is undertaken. The checks included whether the exam is justified, pregnancy status, examination history for recent studies and duplication, correct anatomical area and laterality for exam and that radiation safety measures for staff and/or carers have been taken. Staff knew about the posters and where to locate them, however, there use was not embedded in everyday work. Radiographers did not routinely check the electronic imaging record for all patients and relied on verbally questioning the patient as to previous scans. This meant staff were not following best practice.

Mandatory training: Outpatients

- Mandatory training covered a range of topics, which included health and safety, manual handling, infection prevention control, fire safety, equality and diversity and basic life support (BLS). All staff within the outpatient and diagnostic imaging service were aware of the need to attend mandatory training.
- Training was completed as e-learning modules with some face-to-face sessions, such as mental capacity awareness.
- Senior staff within outpatient services were able to provide mandatory training compliance figures for the department. Staff could access their training record via the trust's electronic staff record, which provided alerts to staff when their mandatory training updates were due. We observed this during our inspection.
- Compliance with mandatory training had improved since the last inspection. The July 2016 training figures showed training compliance in some areas met the trust's target:
  - 93% outpatients department (OPD) staff had attended information governance training

- 98% OPD staff had attended manual handling training
- 100% OPD staff had attended hand hygiene training
- 91% of medical and dental staff within the specialised clinical services division (SCSD) had attended fire safety training
- 94% of medical and dental staff within SCSD had attended manual handling training
- 91% of medical and dental staff within SCSD had attended resuscitation training

- However compliance in some areas of mandatory training were below the trust's 90% target:
  - 84% OPD staff had attended infection control training
  - 84% OPD staff had attended fire safety training
  - 82% OPD staff had attended resuscitation training
  - 87% OPD staff had attended health and safety training
  - 42% of medical and dental staff within SCSD had attended conflict resolution training
  - 27% of medical and dental staff within SCSD had attended equality and diversity training
  - 31% of medical and dental staff within SCSD had attended medicines management training
  - 89% of medical and dental staff within SCSD had attended health and safety training
  - 81% of medical and dental staff within SCSD had attended information governance training
- Team managers were aware of the staff that were not compliant and there were plans to address the non-compliance.

Mandatory training: Diagnostic imaging services

- Compliance with mandatory training in some areas did not meet the trust's target of 90%. The July 2016 training figures showed radiology medical staffing compliance was
  - 63% information governance
  - 83% fire
  - 90% manual handling
  - 83% resus
  - 90% health and safety
  - 93% hand hygiene
  - 83% infection control
- The July 2016 training figures showed radiology staffing compliance as:
  - 91% information governance
  - 82% fire
  - 91% manual handling
  - 91% resus
  - 74% health and safety
  - 96% hand hygiene
  - 85% infection control

Assessing and responding to patient risk: Outpatients

- The trust had a harm review process in place for patients on 62-day cancer pathways, with no reported harms to date. The Clinical Commissioning Group (CCG) told us this information was presented to the executive trust board. The CCG planned to review this process through a themed discussion at the clinical quality review meeting. This review had not taken place at the time of our inspection.
- Information provided by the trust should 5,100 patients had exceeded the 18-week referral to treatment time (RTT). 3,151 patients waited 18 to 25 weeks and 1,949 patients waited 26 to 51 weeks. During the inspection, we were told that harm reviews had not been carried out on patients who exceeded the 18 week RTT. However, according to information provided following the inspection, medical specialities were validating all patients who exceeded the 18-week RTT and reviewed all patients who had waited over 40 weeks on a weekly basis. This included trauma and orthopaedics, gastroenterology, respiratory, neurology, ophthalmology and rheumatology. According to the RTT improvement plan for dermatology, for example, patients who waited over 18 weeks for their outpatient appointment were contacted via telephone / post to ensure their condition remained stable. We were told that root cause analysis (RCA) and harm reviews were carried out on patients that waited longer than 52 weeks to be seen. However, the evidence provided by the trust to corroborate this was of RCAs undertaken back in July 2015. Therefore, due to the conflicting information, we were told and the lack of recent evidence received we were not assured there was an effective system in place to monitor and manage the risk to all patients on the waiting list in a timely manner.
- Staff were aware of what actions they would take if a patient became unwell in the outpatient department. This included a call for urgent medical assistance, Staff gave us examples of when they had appropriately escalated patients who had deteriorated within the department.

- There were emergency call alarms situated in the consulting and treatment rooms in the outpatient department. Staff would use the emergency call alarms to summon urgent assistance as needed, such as when a patient had deteriorated within the department. Emergency call alarms were also situated in the toilets, so that patients could summon urgent assistance as needed.
- During our inspection, we observed that clinical waiting areas were constantly staffed. This meant staff had oversight of patients who were waiting to be seen and could respond promptly when needed.

Assessing and responding to patient risk: Diagnostic imaging services

- The department had a policy for contrast use for patients with renal impairment and a flow chart for contrast administration against GFR results was in place. We saw evidence of these checks at the time of inspection
- The World Health Organisation checklist for interventional radiology had recently been implemented across all modalities in the imaging department within the last few months. Audits had been carried out in November 2016 to check compliancy with using and recording of the checklists. In Ultrasound (US) ten records audited with 30% compliance, in CT three records showed 67% compliance and in interventional 20 records were reviewed with 100% compliance. This demonstrated the Who checklist had not been properly embedded into the process within CT and US. We did not see an action plan to address poor compliance of the WHO checklist.
- The MRI safety-screening checklist was evidenced and this was completed for all patients. These were sent to patients with their appointments and completed documentation was stored on the radiology information system. If there was any uncertainty regarding a patients' compatibility with the magnet this was referred to a consultant radiologist or to the referrer.
- Staff were unsure of the burns policy. While there had been no recorded burns issues within MRI, we were not assured staff would be able to follow the policy or actions to take if this was to occur.
- There was no set specific absorption rate (SAR) in MRI policy, this meant staff generally adjusted rates using professional judgement with no standardised rates between patients. There was however, no reference to SAR levels in the local rules. The specific absorption rate (SAR) in MRI describes the potential for heating of the patient's tissue due to the application of the Radio Frequency energy.
- When there were concerns regarding foreign metallic objects in patients eyes prior to an MRI scan, a senior manager or consultant radiologist acted as a referrer for plain film imaging for the purposes of elimination.
- The medical physics service had recommended an annual review of all radiation risk assessments however staff told us the review was sporadic and not robust. We saw no evidence of a recent review.

Nursing staffing: Outpatients

- Staffing levels and skill mix was planned and reviewed so that people received safe care and treatment. There was no national baseline acuity tool for nurse staffing in outpatients. The matron had carried out a skill mix review in January 2016 to determine staffing requirements across outpatient services. This was used to calculate how many nursing and healthcare assistant staff were required to cover the speciality clinic sessions held per week. The service reviewed the department's skill mix each time, either clinics changed or if staff left. Departments used an electronic rota system to plan and allocate staff to clinics.
- The outpatients department did not use agency staff. When additional staffing was required, for example to cover extra clinics, sickness or annual leave, cover was provided by staff who worked on zero hours contracts, by staff working extra hours or occasionally by bank staff.
- Bank staff received a local induction to the department using a checklist and would be allocated to work with a 'buddy' to support them on their first shift.
- Reception and nursing staff were available to support all clinics running during the inspection.
- New staff completed a competency pack. New starters underwent a four-week induction process and there was a 'buddy' system to support new staff during induction. Induction training included mandatory training, a period of shadowing and a workbook, which had to be signed off to confirm competency levels. Examples of the induction and competency packs were observed during inspection.
- The calculated establishment was 18.22 whole time equivalent (WTE) registered nurses and 22.68 WTE

healthcare assistants. As of August 2016, 17.84 WTE nursing staff and 19.59 WTE healthcare assistants were in post; this equated to a 0.38% and 3.09% vacancy rate for nursing staff and healthcare assistants respectively. Specialties such as ophthalmology, ear nose and throat (ENT) and audiology supplied their own staff to support clinics.

Radiology staffing

- The risk register cited a continuous staffing issue across all staff groups. These issues included an inability to recruit into radiographer and radiologist posts however a contingency plan was in place whereby students due to qualify were being retained.
- There was one nursing vacancy at the time of inspection.
- The department had been proactive in their recruitment issues since the summer of 2016. Eight of the 11 radiographer vacancies had been filled, with a further two members of staff joining in January 2017. The department had looked at foreign agencies and had two radiographers joining from Italy at a band four with a full six-month preceptorship until they gain state registration.
- The trust had been offering substantive posts to students once qualified. Until professional accreditation has been awarded these staff were employed at band four in order to increase the staffing level. These staff were fully supervised until professional registration was gained.
- We saw evidence of new staff undertaking a departmental induction, which included all trust mandatory training sessions and equipment competencies.

Medical staffing: Outpatients

- In the outpatient department, medical staffing was arranged by the individual specialities such as rheumatology, cardiology, gastroenterology and dermatology. Due to the nature of how services were configured, medical staff were required to work across the range of sites within the trust, in order to facilitate outpatient clinics.
- We were told that there was a shortage of medical vacancies across all specialities, including rheumatology, urology, geriatric medicine and trauma and orthopaedics. During the last financial year (April 2015 to March 2016), the trust reported an average vacancy rate of 32% for consultants and 34% for all other grades of medical staff. According to the board report for November 2016, there were 153.3 WTE medical vacancies as of 24 October 2016. This meant there could be a delay in patients being seen for new or follow-up appointments. The trust had identified a recruitment and retention strategy in the patient care improvement plan. However, recruitment continued to be a challenge for the trust. As of November 2016, the trust had successfully recruited to 23 WTE posts, which included 10 WTE consultants, eight WTE career grade doctors and five WTE locum appointments for doctors in training. Commencement of employment dates ranged from November 2016 to July 2017.
- The individual specialities arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of clinics and patient numbers.
- Consultants were supported by junior colleagues in clinics where this was appropriate.
- As of September 2016, Worcestershire Royal Hospital reported a vacancy rate of 10% in outpatients; medical staff – consultants: 20% medical staff – other medical staff: nil.
- As of September 2016, Worcestershire Royal Hospital reported a turnover rate of 16% in outpatients; medical staff – consultants: 16%
- As of September 2016, Worcestershire Royal Hospital had reported no sickness for medical staff in outpatients.
- A number of staff we spoke with told us care had been compromised by financial pressures. Staff told us the hospital had been unable to employ locum staff to fill staffing gaps caused by long-term sick leave or maternity leave due to the agency cap. The cap, was introduced in response to a "very significant financial challenge" facing NHS providers, the health watchdog monitor, part of NHS Improvement. It came into force in November 2015. It set a limit on hourly rates for agency doctors, nurses and other clinical and non-clinical staff. NHS Improvement recognised that agencies could perform an important role by helping align the supply of staff with where they are most in demand. However, trust spending on agency staff had increased to the extent that it was one of the most significant causes of deteriorating trust finances. We heard examples where

medical teams were working with 50% WTE as a result there were lack of access for new patients and follow up appointments for existing patients and the RTT time had increased.

Medical staffing: Diagnostic imaging services

- At the time of the inspection, the trust had six consultant radiologists' vacancies across sites. The departments were looking to recruitment worldwide and were awaiting confirmation of a package to help with the recruitment issues. This includes home working where reporting stations were set up at their resident. Locum radiologists were being used to cover the vacancies. All locum staff completed a local induction.
- There was no provision of out of hours interventional radiologist cover due to the lack of specialised radiologist to provide cover 24 hours a day.

Major incident awareness and training: Outpatients

- The trust had a major incident policy, which staff could access via the trust intranet.
- There was good understanding amongst nursing and medical staff with regards to their roles and responsibilities during a major incident.
- Staff were aware of fire safety precautions and emergency evacuation procedures.

Major incident awareness and training Diagnostic imaging services

- There was a folder in the x-ray viewing area, which included processes for staff in case a major incident was declared. This was easily accessible and all staff in the area were able to locate it.

Are outpatient and diagnostic imaging services effective?

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. We inspected, but did not rate the service or effectiveness.

We found that:

- Radiology clinical audits were adhoc and did not meet the audit requirements of IR(ME)R.
- The consent audit for outpatient and diagnostic imaging was not part of the forward plan for 2016/17 and therefore no audit has been carried out in the last 12 months.
- There was currently no audit schedule within the hospital but we saw some audits were undertaken were discussed at staff meetings.
- From April 2015 and March 2016, the follow-up to new rate patient ratio for Worcestershire Acute Hospitals NHS Trust was lower the England average.
- Staff in MRI were concerned about the lack of continuing professional development opportunities available to them.
- Training records for MRI staff equipment was poor. There was no recorded equipment training for radiologists using the interventional suite and radiographers training records were not always up to date or signed off by assessors.
- There was no out of hour's interventional radiology services due to the inability to recruit specialist radiologists.

However:

- Specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate.
- NICE guidelines for imaging of patients with suspected stroke were met within radiology.
- There was good availability of training opportunities.
- Outpatient nursing staff had the right qualifications, skills, knowledge and experience to do their job when they took on new responsibilities and on a continual basis.
- In house training for mammographers was described as excellent with a designated member of staff to co-ordinate this.
- The occupational therapy department had a formal supervision process in place to support and develop staff.
- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- Staff had the information they needed to deliver effective care and treatment to people who used services.

- Nursing, diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.
- Patients could be referred to specialist pain clinics held at the Worcestershire Royal Hospital, Kidderminster Treatment Centre or clinics held at local community hospital sites. Four anaesthetic consultants with experience in advanced pain medicine led the pain management service. This is in line with the Royal College of Anaesthetists recommendations.
- The trust had up to date policies regarding consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff could access these policies via the trust intranet.
- Written consent to treatment was initiated by medical staff or suitably qualified healthcare professionals during outpatient consultations; this included discussion on the benefits and potential risks of the proposed treatment.

Evidence-based care and treatment: Outpatients

- We saw evidence that specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. For example, the cardiology department followed NICE guidance for the management of atrial fibrillation (a common abnormal heart rhythm characterised by an irregular and rapid pulse) (NICE 2014, Atrial fibrillation: the management of atrial fibrillation).
- We saw evidence that specialities had pathways in place for the management and treatment of specific medical conditions that followed NICE and national guidance. For example, the dermatology department had up to date clinical pathways in place that followed NICE guidance for the management and treatment of specific skin conditions, such as severe plaque psoriasis. Plaque psoriasis is a chronic autoimmune condition. It appears on the skin in patches of thick, red, scaly skin.
- The ophthalmology department had up to date policies and clinical pathways that followed NICE and the Royal College of Ophthalmologists guidance for the management of age-related macular degeneration (a common eye condition and leading cause of central vision loss amongst people over the age of 50 years), cataract surgery and glaucoma, for example. Glaucoma is an eye condition where the optic nerve, which connects the eye to the brain, becomes damaged. It can lead to loss of vision if not detected and treated early on. A cataract is a clouding of the lens in the eye, which leads to a decrease in vision.
- We saw evidence that the physiotherapy department had developed treatment pathways and guidelines, which covered referrals, consent, musculoskeletal conditions, orthopaedics, neurology, rehabilitation, women's health and respiratory conditions and interventions. These had been developed in accordance with best practice and current-evidence based guidance. Treatment pathways and guidelines were reviewed and ratified at the physiotherapy governance forum, or the appropriate specialty governance forum such as trauma and orthopaedics.
- The ophthalmology department had access to six-metre vision lanes, in line with national guidance (The Royal College of Ophthalmologists, Ophthalmic Services Guidance: Ophthalmic Outpatient Department, 2012).
- Staff we spoke with demonstrated how to access policies and procedures on the trust intranet.
- Trust policies were assessed to ensure guidance did not discriminate on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

Evidence-based care and treatment: Diagnostic imaging services

- The consent audit for outpatient and diagnostic imaging was not part of the forward plan for 2016/17 and therefore no audit has been carried out in the last 12 months. Staff told us it would be included in the forward plan for 2017/18.
- A number of local clinical audits had been carried out and had been registered with the trust clinical audit team, audits included:
  - The use of breast MRI in detecting contralateral lobular breast cancer
  - Rectal MRI: Indications, protocols and accuracy
  - Retrospective audit of the departmental use of plain abdominal radiographs in the clinical setting of abdominal pathology
  - Turn over time for paediatric chest X-ray reporting and prostate cancer: Utilisation of MRI in diagnostic pathway (NICE 2014)

- Patients with a family history of breast cancer who fell outside of the age limits for breast imaging attended MRI scans at Kidderminster Hospital and Treatment Centre.
- The medical physics service were consulted for the purpose of establishing research procedures and dose constraints.
- Although a defined audit schedule was not in place, some audits were being carried out. Audits to ensure staff were complying with various regulation were not carried out and therefore there was no assurance that department knew where compliance was poor. All audits undertaken within the department were discussed at staff meetings. Senior managers in the department felt at present not enough audits, especially those required under IR(ME)R were being undertaken. IR(ME)R states that clinical audit must be carried out. We did not see evidence that the service were carrying audits that IR(ME)R would expect around employers procedures and against the regulations.
- The radiation protection supervisor at Alexandra hospital had been attempting to collaborate and standardise audits across all sites and areas of radiation protection, it was felt that this was locally led and not a Trust wide overview.
- When the trust employed an out of hour's radiologist service for CT scans, referral rates increased. Radiologists were concerned that requests that were inappropriate and against local protocol were being accepted, the previous clinical director addressed this and there was an improvement.

Nutrition and hydration: Outpatients

- Patients who attended clinic or diagnostic appointments were not generally in the department for long periods of time, therefore beverages and food were not routinely provided. Clinic waiting rooms did have water coolers. The outpatient's clinic was situated near to the hospital coffee shop, fruit and vegetable stall and shop so patients had easy access to food and fluids if necessary. We observed staff providing hot drinks for patients who had travelled on community transport and had a long wait until their transport arrive to take them home.
- Glucose gel and tablets were available in the outpatient department for patients with diabetes when required. There were stored in a hypoglycaemic box on the emergency trolley. Glucose preparations are recommended when a patient has a 'hypo' and needs to increase their blood glucose levels rapidly (a 'hypo' is commonly used to describe hypoglycaemia, which is where the blood glucose level of a patient with diabetes falls below the normal range).

Pain relief: Outpatients

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy department as required.
- There was no formal pain assessment tool in place to assess whether staff effectively managed people's pain while patients were in the outpatients department. Staff carried out an informal intentional rounding; staff spoke to patients who were in the department for long periods of time to check if they needed any assistance offered fluids and asked if they were in any pain. Intentional rounding was a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. Concerns about poor standards of basic nursing care have refocused attention on the need to ensure fundamental aspects of care are delivered reliably.
- Outpatient clinics had access to simple analgesia and local anaesthetic preparations when required. Senior nursing staff told us that any pain relief needed by patients who attended outpatient clinics was prescribed by a doctor before it was administered and recorded in the patient's notes.
- Patients that we spoke to during our inspection had not required pain relief during their time within the outpatient department.
- Staff and patients had access to acute pain control patient information leaflet, which had been devised by the trust. It advised staff would ask patients if they are in pain and that the trust uses a zero to three pain scale for assessing pain. It also contained information on the different types of pain relief treatment that could be provided.
- Patients could be referred to specialist pain clinics held at the Worcestershire Royal Hospital, Kidderminster Hospital and Treatment Centre or clinics held at local community hospital sites. Four anaesthetic consultants with experience in advanced pain medicine led the pain management service. This is in line with the Royal

College of Anaesthetists recommendations. The pain management service included specialist pain nurses, orthopaedic physiotherapy practitioners and clinical psychology staff.

Patient outcomes: Outpatients

- From April 2015 and March 2016, the follow-up to new rate for Worcestershire Acute Hospitals NHS Trust was lower the England average. This included the three acute sites and two community hospitals. The trust was in the lower quartile when compared to other trusts nationally.
- There was no national target for patients to be seen by a clinician within a specific time. In August 2016, the trust reported 43% of patients waited over 30 minutes to see a clinician. All patients we spoke with told us their appointments never ran to time however; they were kept informed of the length of delay and a reason for the delay.
- At the time of our inspection, an outpatient clinic audit was being undertaken. Staff were required to record the clinic speciality, clinic start time, the time medical staff arrived, the time the first patient was called in by medical staff, the time the last patient left the department and the time the clinic should have finished. This information was collected on a daily basis for each clinic held. The audit commenced in October and the service hope to report on the findings in January 2017. Information from the audit was not available to review at the time of inspection.
- The outpatient department had not historically participated in local or national benchmarking clinical audits; these were undertaken by individual specialities. Each speciality participated in national benchmarking clinical audits, where appropriate, such as bowel cancer screening, diabetes management and chronic pulmonary obstructive disease. This was in line with NICE recommendations.

Patient outcomes: Diagnostic imaging services

- Since the previous inspection in July 2016, the consultant radiographer had set up a programme of audit for the reporting radiographers, which was good practice. This involved service peer reviews of each other's work to improve standards and education. Ten images a month for each radiographer was double reported and rated for inaccuracies and style. Discrepancy meetings for the reporting radiographers had also commenced which also included teaching sessions and review of interesting cases.
- The trust wished to pursue the imaging services accreditation scheme and were looking towards working with a buddy trust in order to achieve this. At the time of inspection, there was no timescale for this as there working on other issues within the department. This was a long-term wish as opposed to an upcoming action.
- Some staff had raised concerns with senior managers and radiologists that the outsourced private CT service was inappropriately accepting CT scan requests. This was followed up by the service and an audit had been carried out. Following this, an improvement had been seen but CT radiographers still have concerns. The managers continue to monitor and record the situation and referrer to a radiologist if further reports or information is required.

Competent staff: Outpatients

- There was good availability of training opportunities. Staff were encouraged to take responsibility for organising their own training. Managers had oversite of the staff training compliance.
- Staff confirmed that they had received updates on mandatory training. The mandatory training data for July 2016 showed compliance with mandatory training had improved since the last inspection. However there was varied compliance across all specialities within outpatient department compliance and in some areas of mandatory training were below the trust's 90% target such as 42% of medical and dental staff had attended conflict resolution training. 27% of medical and dental staff had attended equality and diversity training and 31% of medical and dental staff had attended medicines management training, therefore, we were not assured that all staff had completed mandatory training when required.
- The trust appraisal policy stated that all staff were required to have an annual appraisal. Staff we spoke to told us it was a useful process for identifying any training and development needs. Trust data for July 2016 showed appraisal rates of 96% for outpatient staff.
- Revalidation was introduced by the Nursing and Midwifery Council in April 2016 and was the process that all nurses and midwives must follow every three years to

maintain their registration. The trust had appointed a lead for revalidation. Workshops had been held to support nursing staff with revalidation. There was also a sample revalidation folder, which staff could access for guidance. Several nursing staff within outpatients had revalidated in 2016.

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment. We saw evidence of an induction and competency packs for all new substantive outpatient staff. All new starters underwent a four-week supernumerary induction process.
- We saw evidence that ophthalmology staff had annual training on the use of laser equipment to maintain competence.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they took on new responsibilities and on a continual basis. Appropriate training was available to meet staffs' learning needs. Staff had additional training and qualifications. For example, clinical nurse specialists had at least degree level training and competency training in specified area. Staff were encouraged and given opportunities to develop. All were offered opportunities or further training for example to train to masters' level in advanced clinical practice.
- The outpatient department had "link nurses" for topics such as infection prevention and control, mental health, learning disability and dementia. Link nurses attended additional training and link nurse meetings, and shared their learning with the rest of the team.

Competent staff: Diagnostic imaging services

- The trust appraisal policy stated that all staff were required to have an annual appraisal. 86% of radiology staff had completed their appraisal.
- Staff in MRI were concerned about the lack of continuing professional development opportunities available to them. Staff had been unable to be released to attend training due to the historic staffing issues.
- Training records for using equipment were poor especially for the interventional suite and catheterisation laboratory image intensifiers. Radiologists did not hold any formal training records as evidence that they could use this equipment safely. We were told that staff had received applications training when the equipment was first installed, but found no evidence of this.
- The training records for all radiographers were present. However, the majority of records were incomplete, with either no assessors sign off for competency, or no date of completion. One member of staff had completed equipment training in 1999 and had no update recorded, even for the new equipment installed in 2013. The senior managers were not aware of this issues prior to it being raised by the inspection team. We were told that the managers would look at this at as a matter of importance.
- MRI competency records were seen but an induction pack for new staff was not evidenced.
- All radiographers in the breast unit had completed postgraduate courses in mammography. In house training for mammographers was described as excellent with a designated member of staff to co-ordinate this. Currently there was only one stereotactic trained mammographer who was able to take breast biopsies and three mammographers that were able to report mammograms.
- Radiographers reporting in nuclear medicine provided a positive impact on reporting times; in addition, fast track reporting was available where required. The nuclear medicine radiographer reported on scans, which was quicker than waiting for radiologists to do so.
- There was radiographer reporting in planar imaging and CT.

Multidisciplinary working: Outpatients

- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- Staff, including those in different teams and services were involved in assessing, planning and delivering people's care and treatment. Care was delivered in a coordinated way when different teams or services were involved.
- We observed a one-stop vascular clinic to reduce waiting times and increase the number of patients who received early diagnosis and treatment. Staff worked together to assess and plan ongoing care and treatment in a timely way. Patients could see the consultant and nurse specialist for review and treatment. Dressings would also be reviewed and changed if necessary.

Outpatients and diagnostic imaging

- Treatment and information about ongoing care following appointments, was sent to the patients' GP. When people were discharged from a service, all relevant community teams and services such as district nurses or community care provider were informed.
- Clinical nurse specialist provided support in clinics to support patients. For example, leg ulcer nurse specialist, rheumatology nurse specialist and Parkinson's nurse.
- There were also oncology and cancers specialist nurses that provided support for patients having treatment for cancer of the lung, breast, or having treatment provided by speciality such as gynaecology, urology, haematology and colorectal surgery.
- We saw evidence of regular multi-disciplinary team (MDT) meetings being held. These included urology, dermatology and ophthalmology. Having regular MDT meetings represents good clinical practice as they are an opportunity for all staff involved in a patients care to have discussions about potential benefits and disadvantages of certain treatment approaches.
- Physiotherapists and occupational therapists worked collaboratively with specialties, such as neurology, cardiology, rheumatology, respiratory, women's health and trauma and orthopaedics, to provide outpatient services for patients.
- Occupational therapists worked collaboratively with the rheumatology department to provide outpatient services for patients with hand injuries and symptoms of long-term conditions.
- The ophthalmology department had nurse specialists who were trained to administer treatment to patients with wet age-related macular degeneration (a common eye condition and leading cause of central vision loss amongst people over the age of 50 years).
- Information about ongoing care and treatment was available to GPs, teams and services in a timely way via the electronic patient record system. When patients were discharged from a service the relevant GP, teams and/or services were informed.

Multidisciplinary working: Diagnostic imaging services

- There had been periods where there had been no administration of radioactive substances advisory committees' holder on site due to annual leave and no cross-referencing between radiographer and radiologists over these periods. On these occasions scans could not be carried out, patients were not given appointments at this time and scanned in a timely manner. In nuclear medicine there was good support from nuclear medicine radiologist. The department would like to establish a duty-radiologist with nuclear medicine experience to ensure that the service was not interrupted in the future.
- Nuclear medicine staff cited a, good relationship with clinical teams in particular breast and cardiology services.
- Radiographers in nuclear medicine do not attend MDTs but worked closely with service users. The senior manager had an interest in cardiology, however time constraints, did not always allow for a multi-disciplinary meeting attendance.

Seven-day services: Outpatients

- Outpatient services were not available seven days per week. Outpatient clinics were available from 8.30am to 5.30pm, Monday to Friday. Staff had been working additional hours to provide outpatient clinics on a Saturday between 9am and 12 noon in order to meet patient demand to assist with outpatient backlogs.

Seven-day services: Diagnostic imaging services

- There was no out of hour's interventional radiology services due to the inability to recruit specialist radiologists.
- There were plans in place for full implementation of seven day working at Worcestershire Royal Hospital. However, at the time of inspection there was no start date.
- At Worcestershire Royal Hospital computerised tomography (CT) was open from 8.30am until 5pm for outpatient scans and for inpatients there was a 24 hour, seven days a week service. Radiologists covered this service until 8.30pm and after this time a private radiology service was placed for the purpose of scan justification and reporting of images.
- MRI was open 8.30am until 8pm Monday to Friday, there was no on call MRI service but there were four to six dedicated inpatient slots at the weekend.
- Level one x-ray, planar imaging for GP and clinics was open 8am until 5.30pm for clinics and GP patients Monday to Friday.

Access to information: Outpatients

- Staff had the information they needed to deliver effective care and treatment to people who used

services. Information such as care and risk assessments, care plans, case notes and test results were available to relevant staff in a timely and accessible way. Senior staff demonstrated how to access policies and procedures on the trust intranet. We saw that clinical pathways and policies were listed on the trust intranet according to speciality.

- Clinic rooms had computer terminals, which enabled staff to access patient information such as x-rays and blood results via the electronic reporting system.
- Staff had access to the trust intranet to obtain information relating to trust policies, procedures, NICE guidance and e-learning.
- There was sufficient administration staff to manage the workload.
- GPs received information on the patient's condition in a timely manner.
- GP letters were typed directly into the electronic clinical letter system used by the trust. The electronic system generated GP letters and uploaded a copy to the patient's record overnight, when the system was updated. The turnaround time for GP letters varied amongst specialities. For example, staff told us that GP letters were turned around within one to two weeks for gastroenterology and one to two days for diabetes and endocrinology. All staff we spoke with told us that urgent letters were turned around within 24 hours.
- Information regarding access to support services for safeguarding from abuse was displayed on notice boards in outpatients departments where service users would see it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards: Outpatients

- The trust had up to date policies regarding consent, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access these policies via the trust intranet.
- All clinical staff, which included consultants, junior doctors, nurses and health care assistants, were required to complete MCA and DoLS training three yearly. Training data provided after our inspection for January 2017 showed that 89% of outpatient nursing staff had completed MCA and DoLS training, which was slightly below the trust target of 90% compliance. Therefore, we were not assured that all outpatient nursing staff had up-to-date knowledge of the MCA and DoLS. ENT staff were 71% compliant with MCA and DoLS training. Ophthalmology staff were 100% compliant with MCA and DoLS training.
- Nursing, diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. Staff we spoke with were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected. We observed nursing staff obtain verbal consent from patients before they carried out baseline observations, such as blood pressure measurement.
- Staff said that they had some training in MCA and DoLS as part of their mandatory training.
- The consent audit for outpatient and diagnostic imaging was not part of the audit schedule for 2016/17 and therefore no audit has been carried out in the last 12 months. It would be included in the forward plan for 2017/18.
- The trust had four nationally recognised consent forms in use. These included a consent form for patients who were able to consent, one for children or young persons and another for procedures where consciousness was impaired.
- The trust used electronic consent forms with the exception of consent form four, which was for patients who were not able to consent to investigations or treatment; this was a paper copy form because two consultants were required to complete it.
- Written consent to treatment was initiated by medical staff or suitably qualified healthcare professionals during outpatient consultations; this included discussion on the benefits and potential risks of the proposed treatment.
- Patients told us that staff were good at explaining planned procedures or treatment before they were asked to consent to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards: Diagnostic imaging services

- Consent taken for CT colons and aftercare leaflets were given to patients.
- Verbal consent was used for intimate examinations in ultrasound.
- Staff in MRI were clear on the procedures surrounding patients who lacked capacity.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

Overall, we rated this service as good for caring because:

- Staff were polite and courteous when dealing with patients.
- Feedback from people who used the service and those who were close to them were positive about the way staff had treated them.
- Patients were treated with dignity, respect and kindness during their interactions with staff.
- Patients were involved and encouraged to be partners in their care.
- Patients were provided with the necessary support to enable them to make decisions.
- Staff were observed to communicate with and provided information to patients in a way that they could understand.

However:

- An average of 71% of patients would recommend the service to friends or family. The national average for this period was 93%. However, the response rate was poor with an average 4% this was lower than the England average (7%).

Compassionate care: Outpatients

- We saw patients were treated with compassion, kindness, dignity and respect.
- We observed reception staff greet patients in a courteous and friendly manner and direct them to the appropriate waiting area.
- We saw the NHS Friends and Family Test (FTT) questionnaires throughout outpatient departments with posters, which encouraged patients to leave comments about the service. The NHS launched the FFT in 2013 for all acute trusts. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. The feedback gathered was designed so that services can improve patient experience. We reviewed the FFT data reported to NHS England by the outpatient department from April 2016 to November 2016. An average of 71% of patients would recommend the service to friends or family. The national average for this period was 93%. However, the response rate was poor with an average 4% this was lower than the England average (7%).
- Patients were provided with the option of being accompanied by a friend or relative during consultations.
- Staff told us chaperones were also available if required. The trust had a policy on the use of chaperones, which stated that, wherever possible, the chaperone should be of the same sex as the patient.
- Staff made sure patient's privacy and dignity was always respected, patients told us staff asked the patient for consent prior to any examination and made sure nobody would access the room during the examination or while the patient was getting un/dressed.
- Staff responded to patients who were in physical pain, discomfort or emotional distress with compassion, in a timely and appropriate way.
- Confidentiality was respected, notes where only accessible the staff dealing with patient care and patients were able to speak to the receptionist without being overheard.
- We observed staff introducing themselves to patients making them aware of the roles and responsibilities.

Compassionate care: Diagnostic imaging services

- Patients and those close to them, told us booking staff and clinical imaging staff were "amazing". We saw many compliments that had been written about the service.
- Staff in CT were said to be compassionate and caring by patients and those close to them.
- In nuclear medicine a compliments board was available for staff and public to see. Patients felt staff went "the extra mile".

Understanding and involvement of patients and those close to them: Outpatients

- Patients we spoke with felt well informed about their care and treatment. One patient told us "the nurses are fantastic, I can't fault them".
- Staff communicated with people so that they understood their care, treatment and condition. We saw staff explaining the procedure for the treatment that was being provided for example eyes drops to dilate pupils prior to an eye appointment.

Outpatients and diagnostic imaging

- Staff recognised when people who used services needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We heard reception staff checking if a patient required an interpreter for their upcoming appointment.
- We observed staff speaking to patients to understand relevant treatment options, including benefits, risks and potential consequences. Staff informed patients how and when they would receive test results and where appropriate, their next appointment date and who to contact if they were worried about their condition or treatment after they left hospital. Patients we spoke with felt well informed about their care and treatment. All patients we spoke with were complimentary of the care provided. They felt their questions were answered to enable them make informed decisions about their care.
- Patients we spoke with told us they had received copies of letters sent between the hospital and their GP.
- From the review of notes, we saw patients' preferences for sharing information with those close to them were established and reviewed throughout their care.

Emotional support: Outpatients

- Staff could access the patient advisory liaison service if a patient required a chaperone or advocate as needed.
- There was access to local advisory groups to offer both practical advice and emotional support to patients and carers. For example British lung foundation, sight concern and deaf direct. Information on these services were available in the clinics.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated outpatient and diagnostic imaging services as inadequate for responsive because:

- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment. There were long waiting lists for the majority of specialities including trauma and orthopaedics, gastroenterology, dermatology, thoracic medicine, neurology and geriatric medicine.
- The trust did not consistently meet all cancer targets for referral to treatment times.
- 5,100 patients had exceeded the 18-week referral to treatment time.
- 3,151 patients waited 18 to 25 weeks and 1,949 patients waited 26 to 51 weeks.
- The service did not have a robust demand and capacity assessment in place.

However:

- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend and meant they had access to timely assessments, diagnosis and treatment.
- Translation services were available to patients.
- Feedback from complaints was fed back to staff.

Service planning and delivery to meet the needs of local people: Outpatients

- In response to an increased demand for ophthalmic services, the trust had employed and trained nurse specialist practitioners to treat patients with specific eye conditions such as wet age-related macular degeneration, diabetic macular oedema and retinal vein occlusion. This meant the ophthalmology department had capacity to treat more patients and thereby reduce the waiting times for patients who required this treatment. (Age-related macular degeneration (AMD) is a painless eye condition that causes you to lose central vision, usually in both eyes. Diabetic macular oedema: Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula. The macula is the central portion of the retina, a small area rich in cones, the specialized nerve endings that detect colour and upon which daytime vision depends. Retinal vein occlusion is a blockage of the small veins that carry blood away from the retina. The retina is the layer of tissue at the back of the inner eye that converts light images to nerve signals and sends them to the brain.)
- The ophthalmology service and local Clinical Commissioning Groups (CCG) had established a primary eye-care assessment and referral service, known as PEARS. The service was provided by local accredited opticians in various locations within south Worcestershire and Wyre Forest. Patients who experienced eye problems could self-refer to their local accredited optician, who would assess their condition and would offer treatment, where appropriate. Patients

who required further investigation would be referred to the hospital service. The service had reduced the number of patients who attended the hospital and has meant that patients could be seen and treated in a location that was convenient to them.
- Specialities held one-stop clinics to reduce appointments and waiting lists, such as the vascular medicine clinic.
- The 'did not attend' rate for the hospital was lower than the England average of 7% for seven months of the year from April 2015 to March 2016. There was clear signage to outpatient areas. Receptions were manned during clinic times to assist patients with directions. There were volunteers to help direct patients to their required destination if they needed assistance.
- There was adequate seating and equipment available in all areas of the outpatient department we visited.
- There was insufficient car parking available. Patients told us those who were able, parked off site and walked into the hospital. Patients told us they had to allow at least 40 minutes to try to find parking. Parking machine required cash and parking was paid for on exit. Patients who were frequent users of the car park such as patients attending for regular chemotherapy or radiotherapy could access cheaper parking rates. They could take their parking ticket to the car park office where it would be stamped and allow them a reduced rate. However, some patients told us the car parking office shut at 3.45pm on Monday to Thursdays and 2.45pm on a Fridays. Patients who were attending all day sessions would miss this opportunity and have to pay full rate. There were no plans at the time of inspection to increase the parking on site. Patients attending outpatient appointments were able to access tickets for the outpatients department to reduce the cost of parking if their appointment had run over time.
- Information was provided to patients in accessible formats, such as written information, before appointments, for example contact details, hospital map and directions, consultant name, information about any tests, samples or fasting required.
- Facilities and premises were appropriate for the services that were planned and delivered. Staff were involved in the improvements plan for outpatients. The service held listening in action sessions in June 2016 and July 2016 with staff who worked in the outpatients. The staff identified areas for improvement in their environment. Such as standardised information on notice boards, signage that was suitable for patients living with dementia and access to hearing loops in all outpatient areas.
- Patients with hearing loss could access a text messaging service. Patients could receive information about their outpatient appointment on a message rather than via a phone call.
- Generally clinics were patient centred and there was sufficient seating. We noted there were limited numbers of chairs for people with reduced mobility for example chairs with a higher seat and with arms to making siting and rising from the chair easier.
- There were accessible toilets in each area. Staff had made the areas more comfortable for those waiting there were magazines and information for people to read. Most areas had a separate play area for children with suitable toys and books. The service had a cleaning schedule in place to ensure the toys were cleaned regularly.
- The trust out sourced a radiologist to provide CT cover for requests and reporting from 8.30pm until 9am.

Access and flow: Outpatients

- We were not assured that patients had access to care and treatment in a timely way. National guidance recommends that patients referred for a health condition, should start non-urgent consultant-led treatment, or be seen by a specialist for suspected cancer, within maximum waiting times. Waiting time starts from the point the hospital or service receives a referral letter. The national maximum waiting time for non-urgent consultant-led treatments was 18 weeks. The maximum waiting time for suspected cancer was two weeks. Performance against the 18-week referral to treatment (RTT) standard had been declining since February 2016 and has plateaued around 88% from the beginning of the April 2016. Performance in July 2016 was 88%, which was an underperformance against both the 92% national standard and the trust's sustainability and transformation fund (STF) trajectory of 91%. The challenged specialities were:
  - Thoracic medicine 72%
  - Dermatology 78%
  - Trauma and orthopaedics 80%
  - Neurology 86%

Outpatients and diagnostic imaging

- The July 2016 performance for RTT incomplete pathways was 88%; June 2016 performance was 88%. Oral surgery, general surgery and gynaecology also failed to meet RTT targets but not reported as covered by other services.
- According to information provided by the trust in October 2016 5,100 patients exceeded the 18 week RTT. 3,151 patients waited 18 to 25 weeks, 1,949 patients waited 26 to 51 weeks. The specialities that did not meet the trust target in October 2016 were:
  - Trauma and orthopaedics: 470 patients waiting 18 to 25 weeks and 393 patients waiting 26 to 51 weeks
  - Ophthalmology: 378 patients waiting 18 to 25 weeks and 182 patients waiting 18 to 25 weeks
  - Gastroenterology: 123 patients waiting 18 to 25 weeks and 75 patients waiting 26 to 51 weeks
  - Dermatology: 184 patients waiting 18 to 25 weeks and 101 patients waiting 26 to 51 weeks
  - Thoracic medicine: 169 patients waiting 18 to 25 weeks and 169 patients waiting 26 to 51 weeks
  - Neurology: 150 patients waiting 18 to 25 weeks and 25 patients waiting 26 to 51 weeks
  - Geriatric medicine: 22 patients waiting 18 to 25 weeks and 14 patients waiting 26 to 51 weeks
- From September 2015 and August 2016 the trust's RTT for non-admitted performance was worse than the England overall performance. The figures for August 2016 showed 87% of this group of patients were treated within 18 weeks.
- Ophthalmology specialty were above the England average of 94% at 98% for non-admitted RTT (percentage within 18 weeks). 'Other' specialty was also above the England average of 94% at 93% for non-admitted RTT (percentage within 18 weeks). Rheumatology trust score was the same as the England average of 93%
- Rheumatology, general medicine, ENT, cardiology, gynaecology, trauma and orthopaedics, general surgery, urology, neurology, geriatric medicine, oral surgery.
- Gastroenterology, dermatology and neurosurgery specialties were below the England average for non-admitted RTT (percentage within 18 weeks).
  - General medicine trust score: 92%. England average: 95%
  - ENT trust score: 88%. England average: 92%
  - Cardiology trust score 85%. England average: 91%
  - Gynaecology trust score 84%. England average: 95%
  - Trauma and orthopaedics trust score 82%. England average: 90%
  - General surgery trust score: 78%. England average: 91%
  - Urology trust score: 76%. England average: 90%
  - Neurology trust score: 74%. England average: 89%
  - Geriatric medicine trust score: 73%. England average: 97%
  - Oral surgery trust score: 69%. England average: 88%
  - Gastroenterology trust score: 68%. England average: 86%
  - Dermatology trust score: 64%. England average: 93%
  - Neurosurgery trust score: 64%. England average: 82%
- The trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance and worse than the operational standard of 92% for eight months of the year. From November 2015 to February 2016, the performance was the same as the England average and standard. The latest figures for August 2016 showed 89% of this group of patients were treated within 18 weeks.
- The cardiothoracic surgery, neurosurgery, other, general medicine, ophthalmology, cardiology, urology, ENT and general surgery specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).
  - Cardiothoracic Surgery trust score: 100%. England average: 89%
  - Neurosurgery trust score: 100%. England average: 84%
  - Other trust score: 97%. England average: 93%
  - General medicine trust score: 97%. England average: 95%
  - Ophthalmology trust score: 96%. England average: 93%
  - Cardiology trust score: 94%. England average: 93%
  - Urology trust score: 94%. England average: 91%
  - ENT trust score: 92%. England average: 90%
  - General surgery trust score: 89%. England average: 88%
- The neurology, geriatric medicine, gynaecology, trauma and orthopaedics, oral surgery, thoracic medicine plastic surgery and dermatology specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).
  - Rheumatology trust score: 95% England average: 96%

- Gastroenterology trust score: 91% England average: 91%
- Neurology trust score: 87% England average: 92%
- Geriatric medicine trust score: 88% England average: 98%
- Gynaecology trust score: 85% England average: 93%
- Trauma and orthopaedics trust score: 85% England average: 87%
- Oral surgery trust score: 81% England average: 90%
- Thoracic medicine trust score: 77% England average: 93%
- Plastic surgery trust score: 75% England average: 87%
- Dermatology trust score: 72% England average: 94%

- The trust performed worse than the national standard for patients with suspected cancer being seen by a specialist within two weeks of an urgent GP referral. The trust performance for June and July 2016 was 69% and 76% respectively, against the national standard of 93%. The medical specialities with the highest number of patient breaches in July 2016 were colorectal (178), skin (63), upper gastrointestinal (25) and urology (23).
- The trust performed worse than the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The trust performance for June and July 2016 was 68% and 66% respectively, against the national standard of 85%. The medical specialities with the highest number of patient breaches in July 2016 were urology (18), lower gastrointestinal (11) and skin (5). As at August 2016, the backlog of patients waiting over 62 days to commence treatment was 148.
- The trust had not achieved the cancer two week wait for symptomatic breast patients. The trust performance for June and July 2016 was 56% and 74% respectively, which was significantly below the 93% national target.
- From July 2015 to June 2016, the trust performed consistently better than the 96% operational standard for patients waiting less than 31 days from diagnosis of cancer to receiving their first treatment. From September 2015 to February 2016 the percentage of patients, waiting more than six weeks to see a clinician was lower than the England average. From March 2016 to August 2016 the trusts performance was higher than the England average with figures rising to 6% in May 2016.
- Staff we spoke with were unaware of any patient harm reviews undertaken to mitigate risks to patients who had breached the RTT/cancer waits. According to information provided by the trust following the inspection, we were told that a harm review process was in place for patients on the 62-day cancer pathways whose wait exceeded this target. We were told that no patient harms had been reported to date. We also saw evidence that medical specialities were reviewing patients who had waited over 40 weeks for their first outpatient appointment on a weekly basis.
- We spoke with the chief operating officer who told us that each speciality had a recovery action plan to address patient waiting lists. The trust planned to meet RTT targets by the end of March 2017. Staff we spoke with told us that some specialities, such as cardiology, urology and ophthalmology, put on additional clinics to meet urgent patient demand and reduce backlogs. However, we were also told that some specialities, such as general surgery and thoracic, did not put on additional clinics. We requested evidence from the trust of additional clinics held as part of waiting list initiatives. The information we were provided with showed an additional 408 appointments occurred at the Worcestershire Royal Hospital for the period May to October 2016. The majority of these were in general surgery, Physiotherapy, dermatology and thoracic medicine, with an additional 111, 91, 71 and 43 appointments respectively. Therefore, whilst the trust had taken some action to address patient waiting times, we were not assured that patients had access to care and treatment in a timely way.
- The trust reported 2% of clinics were cancelled within six weeks from May 2016 to August 2016. With 3% of clinics being cancelled with over six weeks' notice in 2016, 4% in June 2016, and 5% in both July and August 2016.
- The main reasons for cancellations as reported by the trust were: annual leave of consultant, on-call commitments, study leave of consultant, professional leave of consultant and meetings. Consultants we spoke to told us that they would try to cover any medical staff shortages, for example due to sickness, by seeing additional patients on their clinic lists. Worcestershire Royal Hospital outpatients department reported that 1,477 clinics had been cancelled between May 2016 and October, 35% (516) were cancelled less than six weeks or less before the appointment date. Care and treatment was only cancelled or delayed when necessary.

- The trust was aware of the moderate to high level of clinic cancellations with less than six weeks' notice across particular specialties. In the short term, the current cancellation database had been updated to ensure divisional directors were aware of all cancellations. The long-term plan was to have an electronic request form that required approval for cancellation of any clinic. The aim was that this process would interface with the clinic scheduling tool so when a clinic was cancelled it would automatically update within the tool, so where possible the room could be utilised by another team; resulting in a reduction in wasted capacity. At the time of inspection, the electronic tool was being piloted. Therefore, we were unable to determine the impact this would have on capacity and service provision. Furthermore, we requested the reasons why the 1,477 clinics had been cancelled but the trust were unable to provide a breakdown of specific information. This meant we were not assured the cancellation database was updated and that divisional directors were aware of all cancellations.
- Patients told us and we saw that reasons for cancellations were explained. Patients told us when appointments had been cancelled they had been supported to access care and treatment again as soon as possible.
- Services did not always run to time but patients were kept informed about disruption. In August 2016, the trust reported 43% of patients waited over 30 minutes to see a clinician. All patients we spoke with told us their appointments never ran to time however; they were kept informed of the length of delay and a reason for the delay. Patients told us they did not complain about the delays, as the service they received during their appointment was satisfactory.
- At the previous inspection, it was unclear whether any demand and capacity assessments had been conducted. This was despite clinic capacity and usage being listed as an objective within the department. At the time of the current inspection, the service did not have a robust demand and capacity assessment in place. The service had started a manual demand and capacity audit in October. Data was being collected until 1 December and it was planned to report on the finding to the divisional leads in January 2017.
- Referrals and appointments were managed centrally by the booking centre. Referrals were triaged upon receipt to ensure that urgent patients were prioritised. If patients could not be booked within the required time frame, the relevant consultant would be contacted and asked if it was clinically acceptable for the patient to wait to be seen. If it was not, the patient would be regraded so that an appointment could be arranged within the required time frame. Two patients we spoke with told us they had received appointment dates by post after the appointment date.
- Staff told us they were concerned about the methods used in order to address the issues with the RTT. The trust had written to patients waiting over 18 weeks for their appointment to inform them of the delay and asking if they still needed the appointment. The letter also informed the patient if the trust did not have a response from them within two weeks, their name would be removed from the waiting list. There had been historic concerns about delays in appointment letters for example letters being received after the appointment date. Staff were concerned in some cases the patients may receive the letter from the trust too late to respond. There was also a concern that not all patients received correspondence from the trust, for example patients had previously complained they had not received appointment letters at all and staff were concerned some patients may not have received the letter. Staff were also concerned, as clinical staff had not been involved in the process as far as they were aware. Clinical leads had not triaged patients to receive letter, no harm reviews had been carried out. A clinical harm review was to give assurance to patients, patient groups, commissioners and the public as to whether any patients have been harmed because of the delay.

Access and flow: Diagnostic imaging services

- Waiting times for patients once they arrived at the department for radiology was not monitored at present, however the management team were currently exploring options for systems that capture and display outpatient data.
- Demand in ultrasound was in excess of capacity and had been cited on the risk register as a moderate risk. There were vacancies in the department and staff told us that some staff members had been off sick due to the pressures that they felt at work. Two radiographers were recruited for training posts in September but this was a

long-term plan due to the two-year training programme. In an attempt to reduce, the pressures bank staff and agencies had been utilised in an attempt to reduce the pressures.

- The auto reporting policy for patients that had undergone a medical exposure but did not require a formal radiological report has been approved within radiology and was available on the intranet. This ensured that radiographers were aware which examinations required no formal report and ensured that regular audit were carried out on those images which required a clinical evaluation by the referring clinician associated with them.
- At the time of inspection, all CT scan appointments were booked within two weeks, with the exception of one patient.
- The stroke pathway timings were met by CT. All stroke patients received head imaging within the hour; priority was always given to emergency department patients.
- In order to make booking of appointments more streamlined, four senior CT radiographers were able to justify referrals and assign appropriate examinations to be booked. This had been implemented due to shortages in the radiologist workforce, causing a bottleneck in the vetting of requests.
- There were plans for all staff that covered the emergency department to be trained in head imaging in CT; this would further improve response rates for the department, as this was by far the most common CT request out of hours.
- CT staff and senior managers felt that the two-week wait was met only due to waiting lists being carried out, there were three separate waiting lists across the sites. The service utilised all scanners across the trust to maximise scan slots.
- Plain film appendicular skeleton images for patients attending the minor injuries unit were reported almost immediately as there was a hot reporting radiographer reporting during the core working hours. The hot reporting session was carried out at any of the three sites within the trust, with images available on the picture archiving and communication system (PACS) system on all sites as soon as the patient examination had been completed.
- Part of the strategy following the enforcement action in July 2016 was to increase the number of cold reporting sessions undertaken by the radiographers. Cold reporting is any image reported outside of the immediate reporting facility for example, if a patient is imaged and the x-ray reported in the emergency department immediately this is classed as hot reporting, if the image goes into a reporting silo/batch and is reported at a later date this is classed as cold reporting.
- Patients who had undergone symptomatic breast imaging were not automatically removed from their screening schedule, which resulted in early screening recalls, which were not required. Staff were aware that this process did not re-set for such patients. There were systems in place to prevent unnecessary exposures, the pre-exposure checks incorporated checking back to previous imaging and clinical history to ensure patients did not undergo unnecessary exposures to radiation.
- Vacuum assisted breast biopsy patients were examined at a neighbouring trust, as this facility was not available locally. This was good practice to prevent women undergoing unnecessary medical exposures.
- Breast imaging staff found the building an excellent facility but felt that they were too remote from the rest of the hospital. There was a risk to continuity of care as women in oncology and surgery had to walk across the site to reach the imaging department.
- The department utilised a short notice cancellation system whereby patients who were able to accept short notice appointments were contacted if an appointment becomes available due to a cancellation or a did not attend (DNA).
- The nuclear medicine department had developed a case for a SPECT camera, which in turn would allow the department to repatriate some imaging capacity, which was currently outsourced to another local trust. A SPECT camera is a single-photon emission computed tomography-imaging technique using radioisotopes. This is a modern CT scanning technology using isotopes which allows for 3D imaging and therefore provides improved diagnostic quality for the detection of pathologies.
- The radiology information technology (IT) manager stated that there were issues with the new IT structure in the trust since a change to a private provider. There were access and flow issues relating to logging IT faults. There was a risk as it took longer to get IT issues resolved as the logging process went through a service desk outside of the country where as previously the radiology PACs lead only has to pick up a phone to a local IT staff member to solve any issues.

Outpatients and diagnostic imaging

- The current waiting time for plain film reporting was 0.6 days for any urgent request and 1.89 days for routine imaging.
- Following an enforcement action served on the trust in July 2016, reporting times had improved this was now an excellent process and far exceeded most trusts in the country.

Meeting people's individual needs: Outpatients

- Staff could access interpreting services either by phone or could request a translator to accompany patients for appointments.
- Hearing loops was available within the outpatients department.
- Staff showed patients in the department information leaflets relevant to their condition and told them where they could access additional advice. For example, support groups such as the royal national institute of blind people to make sure that people who used services were able to find further information or ask questions about their care and treatment. We saw a wide range of information leaflets for patients in all areas of outpatients. Some leaflets had been produced by the trust and some were from national organisations, such as the British Heart Foundation, British Association of Oral and Maxillofacial Surgeons Arthritis Research UK and the Royal National Institute of Blind People. The leaflets we saw were all in English. Staff told us they could access leaflets in other languages if necessary.
- Staff we spoke with had awareness of patients with complex needs and those patients who may require additional support. Staff told us that patients with dementia or a learning disability would be prioritised and seen as soon as possible to reduce anxiety during their visit to outpatients. We saw examples where outpatients' staff had liaised with learning disabilities nurse to support a patient with specific needs in clinics.
- We observed notice boards in outpatient and diagnostic imaging departments contained information about domestic abuse and safeguarding.
- The outpatient clinics we visited were generally accessible to patients living with physical disabilities and wheelchair users.
- The plaster technicians had a designated room for completing plaster cast renewals. There is a variety of plasters available for children so they could choose what colour and/or design they wanted.
- Patients and visitors had access to a water cooler in clinic waiting rooms.
- A café and shop was situated by the main entrance of the hospital, which patients and their relatives or friends could visit to purchase hot and cold drinks, snacks and meals if they wished.

Meeting people's individual needs Diagnostic imaging services

- Departmental signage, in particular signposting to the way out was poor. There was a risk that patients could get lost on their way into and out of the department.
- Posters with patient information relating to CT scans and the contrast media were available.
- There was also information for staff and patients about how to get results as well as information about the patient advice and liaison service (PALS) how to make complaints and safeguarding information.
- Translation services were available.

Learning from complaints and concerns: Outpatients

- The trust reported that there were 123 complaints regarding all outpatient and diagnostic areas at Worcestershire Royal Hospital from December 2015 to December 2016. Themes included for example, delays in appointment times, not being able to contact service to discuss appointment times. All complaint were investigated, 72% (88) were responded to and closed within the trust target. Therefore, we were not assured that all complaints were dealt with in a timely manner and in accordance with trust policy.
- The complaints team allocated complaints, which required investigation to the outpatient's matron. The matron contacted each complainant to apologise and speak with him or her directly about areas of the service they were unhappy with before they formally responded to the complaint.
- Complaints were discussed with staff in outpatients to raise their awareness of how their actions could be negatively perceived by patients. Staff we spoke to confirmed they were aware of complaints and had received feedback via team meetings. We saw evidence of learning from complaints in team meeting minutes.
- Patients we spoke with knew how to make a complaint or raise concerns; Information was available on the trust website and also throughout the hospital, which provided details of how patients could raise complaints about any aspect of care they had received.

Outpatients and diagnostic imaging

- Once a complaint had been investigated, we saw the outcome had been explained appropriately to the individual. There was openness and transparency with how complaints and concerns were dealt with.

Learning from complaints and concerns: Diagnostic imaging services

- There was one recorded complaint about long waits for radiology results this was addressed following on from the section 31 served in July 2016 and reporting times are no longer an issue at the trust.
- One patient was injured whilst undergoing a DXA scan, this was due to an issue with the scanner and the manufacturer has rectified this. Two patients were injured following a mammogram whereby they sustained skin tears. There was a protocol in place but the radiographers were not aware of it at the time. These complaints were shared at staff meetings in the breast-imaging department and staff were made aware of the policy.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated outpatient and diagnostic imaging services as inadequate for well led because:

- We could not be assured the outpatient's service had a robust, realistic strategy for achieving the priorities and delivering good quality care.
- The radiology strategy lacked detail to enable planning of required action plans and did not contain timeframes.
- The outpatients' service was in the early stages of reviewing the departments demand and capacity as part of the efficiencies and productivity work stream in their improvement plan. This information was not available for review at the time of inspection
- Monthly performance information on number of cancelled clinics and the reasons why was not available for outpatients as a whole service. However, from December 2016, the information would be reported to the executive board.
- Due to the lack of radiology representation at divisional level, senior managers felt that there was a lack of understanding of radiology processes and workflow and issues were dealt with in a reactive manner, rather than proactively.
- Radiation protection governance and infrastructure was poor and we were not assured that all requirements under the statutory radiation regulations were being met. There was not a coordinated and trust wide overview of radiation protection issues and actions.
- We were not assured that replacement of aging and unsafe radiological equipment was being adequately prioritised.

However:

- Progress against delivering the improvement plan was monitored and reviewed.
- Senior staff we spoke to felt that outpatients was represented at board level by the chief operating officer (COO). However, the COO had only been in post since early November 2016.
- Staff reported that local leadership within the department was strong, with visible, supportive and approachable managers.
- Since the visit in July 2016 from the CQC, the consultant radiographer told us the department had improved its focus and drive to improve reporting turnaround times particularly for plain film reporting.
- Staff were proud to work at the hospital. They were passionate about the care they provided for their patients and felt they did a good job.
- Outpatient and diagnostic staff felt informed of plans for outpatient services and were encouraged to share ideas of how to improve the services.
- Following enforcement action in July 2016, the reporting radiographer service was more sustainable due to the increase of reporting sessions.

Leadership of service: Outpatients

- The trust had changed the divisional structure since the last inspection in July 2016. Since November 2015 the outpatients department sat within the specialised clinical services division. The divisional operational manager, divisional medical director and divisional director of nursing managed the division. The outpatient department was managed by the directorate

manager for outpatients, endoscopy and bowel cancer screening and a matron. Each clinical area had a nominated sister who worked and manage the clinical speciality.

- Staff reported that local leadership within the department was strong, with visible, supportive and approachable managers. Staff felt there was a positive working culture and in all areas we visited staff felt there was a good sense of teamwork. We observed positive and friendly interactions between staff and local managers.
- Staff told us that they knew the executive team and that they were visible on the 'shop floor' at times.
- The outpatients department was led by the matron, who was responsible for overseeing the provision of outpatient services trust wide and was supported by an operational manager.
- Senior staff we spoke to felt that outpatients was represented at board level. The chief operating officer (COO) was the executive lead for the outpatients improvement programme and told us that patient waiting lists was one of the top three priorities for the trust. However, the COO had only been in post since mid-November 2016. This meant we were unable to determine how effective the executive leadership was and whether they understood the challenges within the service and had identified actions needed to address them.

Leadership of service: **Diagnostic imaging services**

- At the beginning of 2016, there had been restructuring of the radiology directorate. A number of management posts within radiology were new, and roles and responsibilities changed.
- A new clinical director was announced during the week of the inspection. Multiple members of staff of various grades and specialities were extremely positive about the change. The new clinical director has tackled numerous tasks even prior to their appointment; staff had confidence in their abilities.
- Multiple members of the radiology senior management team had told us that there had been some issues with the management structure within the directorate. This has been rectified and staff were now in post. This would help to assist with reviewing incidents.
- Three senior radiographic staff we spoke with felt that at divisional level no one really understood radiology and were reactive to issues in the department as opposed to being proactive, they felt that local leadership was good but divisional and trust leadership was poor. There was no representation of radiology at divisional level and this led to risks on the risk register being downgraded without radiology's knowledge.
- Since the revision of the management structure, we were told managerial members of staff were more accessible, were approachable and visible both when they were needed and on a general, day to day basis. Radiographers spoke highly of the local management.
- Numerous staff told us that they felt that historically the hospitals within the trust were acting independently with no sharing of practice or information.
- There was no vision representing the radiology departments across all the hospital sites. The new clinical director aimed to be proactive towards working collaboratively between the hospital sites and standardising processes and procedures.
- Radiographers spoke highly of the site superintendent.
- Each x-ray modality had a lead radiologist who the cross site senior manager felt should head dose optimisation as required under IR(ME)R. Each radiologist should have oversight and leadership of dose and image quality audits for each of their areas but due to the lack of radiation protection infrastructure; there were no clear lines of accountability for this task. This meant that there was no assurance that doses were sufficiently optimised as part of an appropriate programme to ensure radiation doses were kept as low as reasonably achievable.
- The department has a highly motivated and skilled picture archiving and communication system (PACS) and radiology information system (RIS) manager who led a team of three highly skilled staff and actively managed to cover all of the trust sites to offer support and troubleshooting on a weekly basis.
- There has been the implementation of a trust wide CT superintendent meeting; this was to achieve peer review, standardisation and sharing of working practices. There had been a long wait for this to occur, this meeting rotated through the sites so each lead could view the other departments in the trust.

Vision and strategy for this service: Outpatients

- The trust vision was focused on providing safe, effective, personalised and integrated care for local people by a skilled and compassionate workforce. The department had developed a mission for the service, based upon

the trust vision, which was to deliver the highest standard of care to all patients by actively promoting a supportive, caring and clean environment. This was publically displayed within the department. The trust values were based on the acronym "Pride", which stood for patients, respect, improve and innovate, dependable and empower. Staff we spoke with were aware of the vision and values and were able to describe them.

- We could not be assured the outpatient service had a robust, realistic strategy for achieving the priorities and delivering good quality care because the service did not have a ratified strategy in place at the time of our inspection. We were told by the directorate management team that a three-year outpatient's modernisation strategy had been devised and had been submitted to the executive board for approval. The strategy was focused on improving referral to treatment times, reducing waiting times, improving the outpatient environment, improving efficiency and productivity, developing clinic room scheduling and utilisation and devising standards and operating procedures across all hospital sites. However, because the strategy had not been ratified at the time of our inspection we were unable to determine whether the trust would be able to deliver the strategy and what impact it would have on service provision. We were told that the division planned to present the strategy early in 2017, although no deadline for this had been identified at the time of our inspection. We requested a copy of the unratified strategy but were not provided with this.
- The trust did provide a position statement on the outpatient improvement programme, which set out a broad three-phase strategy for outpatients over the next three years; dated November 2016. However, this did not include details of when they expected to meet the different phases of the strategy and also lacked detail on how objectives would be met. For example, the position statement stated that a detailed plan to deliver phase two of the strategy was being developed. Furthermore, because the strategy had not yet been presented, staff we spoke with were not able to describe their role in achieving the strategy.
- Divisional leads told us the aim of specialised clinical services division was to facilitate safe patient care, delivered by a united, skilled and appreciated workforce. Much of the divisions work was to ensure the correct resources were in place to allow patient care to be undertaken by other directorates. The division's intention was to help the trust to deliver the correct services on the correct site in the county, ensuring adequate clinical support and provision of standardised pathways and equipment. However, most staff we spoke with were unable to identify these aims.
- A project manager had been employed in May 2016 to look at driving improvements in the outpatient department. The trust had recognised the outpatient departments were fragmented and there was a need to standardise process across all outpatient clinics in the trust. The service was in the process of detailed understanding of all service provided within the department. A number of work streams had been identified which included:
  - Environment:
    - Information: The service aimed to standardise information available for patients in the waiting room. Produce a standardised communications folder for each outpatient site.
    - Cleanliness: Develop generic / consistent cleaning schedules for clinical areas in outpatients.
    - Patient care: Notify patients of clinic delays in real time.
    - Safeguarding: To provide adequate signage that was suitable for dementia specific patients. Provide hearing loops with all outpatient areas across each of the hospital sites.
    - These actions had been marked as completed and evidence of action within the department.
  - Standard and operation procedures
    - Devise standards and operating procedures for all outpatient staff and clinics. The first draft completed in September 2016 and had been circulated for comment.
  - Clinic room scheduling and utilisation
    - Develop / Update current tool for clinic room and outpatient staff utilisation. We saw these actions had been marked as completed and evidence of action within the department.
    - Devise standards for all outpatient departments and measures to ensure these are being maintained. This was still in progress at the time of inspection.
  - Efficiencies and productivity

- Performance: A full understanding of current performance by specialty for outpatients. Identify any efficiencies that can be made as a result of late/ overrunning clinic. This was still in progress at the time of inspection.
- Measures: Utilise metrics for reporting and monitoring of progress/impact / success of project - PCIP Reports. To have consistent reporting mechanisms in place from information team. We saw these actions had been marked as completed and evidence of action within the department.
- SMS text reminder: SMS text reminder to be switched on for all clinics minus agreed specialities. This was still in progress at the time of inspection.
- Breast Unit: Breast Unit supplies delivered to the correct location. This action had been marked as completed and evidence of action within the department.

- Information and communications technology (ICT)
  - Televisions: All televisions within outpatients working.
  - WI-FI: Advertise Wi-Fi provided information in all outpatient areas. Provide free Wi-Fi to all patients within the outpatients area.
  - Patient Survey: Provide patient surveys within outpatients - (OIP relating questionnaires).
  - SMS Text Reminder: SMS text reminder system to be configured so patients are automatically opted in with opportunity to opt out. These actions had been marked as completed and evidence of action within the department.
- Strategy
  - Modernisation: Develop a three-year outpatient's modernisation strategy. At the time of inspection, a draft modernisation plan had been devised and had been submitted for approval to the executive board.

- At the previous inspection in July 2016, it had been unclear from our discussions with the nursing lead for the outpatient department whether any demand and capacity assessments had been conducted. This was despite clinic capacity and usage being listed as an objective on the department's strategic document. On the current inspection, we saw the service was in the early stages of reviewing the departments demand and capacity as part of the efficiencies and productivity work stream in their improvement plan. The service had started a manual snap shot demand and capacity audit. Outpatients' staff were recording information on when clinic started late or overran and the reasons for this, number of patients booked for appointments and time the medical staff arrived for clinics. Data was being collected from 10 October 2016 until 1 December 2016. The project manager planned to report on the findings to the divisional leads in January 2017.
- Historically, monthly performance information on number of cancelled clinics and the reasons why was not available for outpatients as a whole service. Performance information was reported on by specialty. From September 2016, information was made available to the divisional lead and from December 2016, the information would be reported to the executive board.
- Progress against delivering the outpatient improvement programme was regularly monitored and reviewed. The project manager reported progress on a weekly basis to the divisional operations manager and the executive director for strategy and planning. A monthly review was presented to the trust executive improvement board. Whilst some progress had been made, the trust did not expect to complete this programme until March 2017. Therefore, at the time of inspection we were unable to determine whether the trust would be able to deliver the outpatient improvement programme and what impact it would have on service provision.

Vision and strategy for this service: Diagnostic imaging services

- There was an existing strategy document for diagnostic imaging services under review. At the time of inspection, there was no completion date identified. The service planned to carry out a capacity and demand model countywide, reviewing staffing and equipment availability. This was to provide further detail to support a decision on CT out of hours working. The out of hour's service (after 11pm at Worcestershire Royal Hospital and 8pm at Alexandra Hospital) was provided by on-call radiographers. The capacity review would also provide details of the skill mix and allow for an informed decision on required skills countywide to maximise services and efficiencies. Each of the identified service developments would be assigned and managed under the newly implemented work streams; this would support implementation and governance and provide overview and management, led by clinical leads.

- The strategy document lacked detail. There was no assigned responsible person for the strategy within radiology.
- The consultant radiographer had a vision for the department, which had not been formalised yet. For example, they planned to look into radiographer led-discharge. At the time of inspection, there was no date identified for this.
- The nuclear medicine department felt management was supportive, moving forward the department would like to procure single-photon emission computed tomography (SPECT) equipment. This is a modern CT scanning technology using isotopes which allows for 3D imaging and therefore provides improved diagnostic quality for the detection of pathologies This would be key to recruitment of new and skilled staff. Senior staff stated financial justification for equipment procurement was challenging.

Governance, risk management and quality measurement: Outpatients

- Senior staff we spoke to felt that outpatients was represented at board level. The COO was the executive lead for the outpatient care improvement programme. However, the COO had only been in post since early November 2016.
- The outpatient department maintained a quality governance performance dashboard. The dashboard included data on mandatory training and personal development review compliance, incidents, complaints, audits and National Institute for Health and Care Excellence (NICE) guidance compliance. The dashboard was maintained by the specialised clinical services divisional quality governance team and was reviewed at divisional and directorate governance meetings. We were told that the trust was in the process of developing a new safety and quality information database, but this had not been implemented at the time of our inspection. We reviewed three sets of outpatient team meeting minutes and there was no evidence to show that results of the quality governance performance dashboard were shared with staff.
- The outpatient service did not participate in clinical audits and compliance to NICE guidance. We were told that clinical audits were undertaken by individual medical specialities.
- We saw evidence that regular reviews were held to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department. Progress was monitored at monthly governance meetings.
- The quality improvement programme detailed performance measures for the outpatient department. These included the audit of start and finish times for outpatient clinics, the monthly outpatient clinic performance report, the number of incidents reported due to overbooking of clinics and the number of complaints reported due to long waits in clinic. We saw evidence that senior staff in the Sorrell Suite were auditing what clinic rooms were used and by whom, the time the clinic room was ready for use, the time the first patient entered the clinic, the time the last patient left the clinic, the time the clinic finished, the longest waiting time. This information was recorded daily for every clinic session. However, at the time of inspection, this data was not available for review, nor was it clear whether this audit was undertaken in all outpatient departments. The audit was due to be reviewed in December 2016.
- The risk register did not represent all the risk identified by the leads for the service. The majority of risks related to diagnostic equipment. We asked the leads what the biggest risk to the outpatients department were, staffing was identified but this was not on the risk register. Information about the, 5,100 patients who had exceeded the 18-week referral to treatment time (RTT). In addition, how to monitor and manage the risk to all patients on the waiting list was not mentioned on the risk register.
- We saw evidence that patient waiting lists were reviewed on a weekly basis. This meeting was led by the head of elective performance and patient access. Each medical speciality had developed an action plan in order to improve RTT performance and sustainability. The chief operating officer told us the trust did not expect to meet RTT targets until the end of March 2017. Whilst some progress had been made against specific objectives detailed within the action plans, we saw that some actions had been rated as amber and red, which meant they were behind the target date for completion. Therefore, we were unable to determine whether the trust would be able to meet its planned trajectory targets and what impact this would have on patient waiting lists.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement: Diagnostic imaging services

- A new radiology governance lead had been in post since February 2016. They told us they had felt frustrated and unsupported at the beginning, with a lack of clear objectives set. We heard that there was also a lack of action plan that would had given this role a clear focus. The role was developed to manage incidents, work towards imaging services accreditation scheme (ISAS) accreditation, to standardise policies across the trust and to undertake actions and liaise with the CQC at the time of the inspection.
- Staff told us the governance lead was positive about the new management and governance structure and believed that this would mean their role would benefit from better support and guidance.
- Prior to the inspection, through data requests, we were told that the imaging department did not utilise the WHO interventional checklists. The governance lead told us that this was now fully implemented and was in the process of having its compliancy audited. There had also been a review of National Safety Standards for Invasive Procedures (NatSSiPs) and which procedures were required for review locally.
- We saw evidence of minutes from the directorate quality governance meetings, which covered governance across the directorate. At the time of the inspection, a newly developed radiology clinical governance team met monthly and discussed local governance of radiology including the risk register, complaints and incidents.
- The risk register included a range of risks across the trust such as aging equipment, staffing levels and the reporting backlog. Following a new governance structure implemented in January 2016, the risk register was being reviewed by the local teams, which was felt to be more effective.
- Incident management was not well managed prior to the new governance team. Incidents were not reviewed as per trust policy as senior managers did not prioritise this. Since July 2016, training had been provided to the site leads to conduct reviews of incidents. At the time of inspection, incidents were routinely reviewed as per trust policy and there was greater oversight of radiology incidents and actions.
- The trust held an annual radiation protection committee (RPC), which was chaired by the clinical director. However, it was unclear how the RPC fed into trust wide governance structure. Last year's meeting had highlighted the lack of radiation protection supervisors within the trust. This had not been rectified at the time of this inspection. The RPC minutes in 2015 highlighted multiple areas where departmental actions were required. At the time of this inspection, many of these actions were still not completed such as images quality deterioration on aging equipment, variations on performance of rooms across the trust and accuracy of exposure settings. It was cited during the inspection that due to staffing, pressures of the clinical workload, finances and lack of training opportunities very few of the recommendations had been carried out.
- The cross-site senior manager held six weekly team lead meetings, where radiation protection was a standing agenda item and any concerns were raised to the directorate and divisional meetings.
- Staff stated that issues and risks were always fed up to the division leads but that there was little in the way of feedback from this level. Items were placed on the risk register and removed without explanation. We saw evidence of monthly team lead meetings were held where all site superintendents met with the cross-site lead to share items discussed at directorate level in order to disseminate information to local sites.
- There was no capital replacement programme for the diagnostic imaging department across the trust. At the time of the inspection, the majority of imaging equipment was owned by the trust. There was several pieces of equipment that were on the risk register as being end of life or failing repeatedly. The trust had said that the equipment that needed replacing must be done under a lease due to financial restrictions. At the time of the inspection, there were no plans in place to replace this through capital procurement and that only way of replacing the equipment would be to lease it with the cost absorbed by the radiology department. It was felt that there was a lack of forward planning to replace very costly equipment for which failures had trust wide impact for patient throughput and access.
- Several members of staff we spoke to highlight their concerns about patient safety due to aging equipment, parts being obsolete and the equipment was mechanically not sound. The equipment was medically sound for undertaking radiological examinations;

however the equipment itself was not medically sound. For example, there was an incident where a chest stand for one of the x-ray machines had fallen off, injuring a patient.

- The cross-site senior manager was looking into ways to generate income in order to fund capital replacement items, one of which was to restructure the cost coding for ultrasound examinations in order for work carried out to be more effectively charged appropriately.
- A senior manager was constantly concerned about service delivery at the hospital due to room closures because of aging and faulty equipment. Nothing was being undertaken to address this at the time of inspection. The concerns were on the risk register but there were no actions in place.
- We carried out an unannounced inspection at Worcestershire Royal Hospital on 27 July 2016. The purpose was to look at specific aspects of the care provided by radiology services at Worcestershire Acute Hospitals NHS Trust following a member of the public initially raising concerns. The trust was given the opportunity to respond to these, however satisfactory assurances were not received. The team reviewed the time taken to report on routine and urgent plain film x-ray examinations, and the governance processes in place to ensure that any backlog in reporting was managed escalated and resolved. We also looked at staffing within the department.
- During the inspection, we found radiology could not provide us with evidence of board oversight or knowledge of the backlog. This meant we were not assured that there were suitable governance and escalation processes in place to protect patients from actual or potential harm. Lessons were not being learnt from incidents and safety goals had not been set. The length of time for the reporting of diagnostic imaging tests had been on the trust risk register since 2003 and we saw no evidence of a review of the situation and clear actions to reduce the backlog.
- During our inspection in July 2016, we found that from 1 January 2016 to 26 July 2016, 10,442 plain film x-ray examinations remained unreported. Subsequent to our inspection, the trust submitted data demonstrating that the total number of unreported images from 2013 to 2015 was 25,622. There were no procedures in place to trigger the escalation of risk caused by lengthy delays in reporting. A full report was published in November 2016.
- On the inspection in November 2016, we found the trust had resourced the radiology reporting issue and the backlog no longer existed. There was a more robust action and escalation plan in place with greater clarity at departmental and board level of the situation in radiology.
- At the previous inspection, enforcement action was served on the trust and actions were placed on the trust to; reduce the backlog of imaging that required reporting, report weekly reporting turnaround times and put an action and escalation plan into place to ensure that this situation did not arise again. The trust was also required to lay out an audit schedule around the reporting of medical exposures. At the time of the inspection, the reporting figures were zero backlogs for the years 2014, 2015 and 2016 with an agreed risk assessment not to report anything more historic. The current report waiting times for plain film imaging were half a day for urgent and less than 48 hours for routine. This demonstrates that the department had utilised external and internal additional reporting capacity and had resourced the action plan at trust level to ensure the requirements of the notice had been met.
- The trust were reactive to the initial issue and demonstrated that there was no proactive approach to the reporting backlog, subsequent to the enforcement action there was a more longer term strategy. There had been an increase in cold reporting sessions for radiographers, employment of additional staff had enabled a more robust and sustainable workforce. There was a new radiographer to undertake chest and abdominal x-ray reporting which was where the majority of the reporting delays were found.

Culture within the service: Outpatients

- Staff were proud to work at the hospital. They were passionate about the care they provided for their patients and felt they did a good job. Staff did not express concerns about bullying or harassment to the CQC team during our inspection.
- Nursing staff within the outpatients department told us they felt respected and valued. They talked of strong local leadership who supported them on a day-to-day basis. However, medical staff did not provide the same assurance. Medical staff did not feel supported on a day-to-day basis.

- Multidisciplinary teams worked together and were focussed on improving patient care and service provision.
- Staff we spoke with reported an open and honest culture within the outpatient department. Local managers were supportive and approachable and staff felt confident to escalate concerns and report incidents.

Culture within the service: Diagnostic imaging services

- Since the inspection in July 2016, a staff told us the department had improved its focus and drive to improve reporting turnaround times particularly for plain film reporting. Previously it was felt there were restrictions on improving the reporting radiographer services due to the culture of both the radiologists and reporting radiographers. Staff felt the enforcement actions placed upon them in July 2016 were "the best thing that could had happened to us".
- Staff in MRI generally rotated between sites within the trust. Radiographers in MRI were concerned about poor communication between sites with no central message, and poor email communication and a lack of standard protocols between sites. There appeared to be a lack of confidence in management and staff in this area had low morale. We were told that MRI senior managers did not rotate enough and were only due to be in Kidderminster one day in December.

Public engagement: Outpatients

- There was some evidence that people who used the services were engaged by the department to help shape and improve them. For example, the outpatient improvement programme was using feedback gathered from patients to improve the outpatient environment. Data collection was from August to the end of November 2016. Patients were asked to rate the outpatient environment, facilities, staff and their overall impression of the department and care they received. We saw that the majority of feedback from patients was positive. For example, 96% of patients rated their overall care as excellent, 4% rated it as adequate and less than 1% rated it as poor.
- Since our previous inspection date in July 2016, the service had commissioned an external outpatient survey. Data was collected in May 2015 and the results were published in December 2015. We saw evidence that the service had developed an action plan in response to results of the survey. For example, actions taken in response to patients who felt they were not kept informed of clinic delays included regular updates of whiteboards with clinic running times and announcements to patients in the waiting room. Reception staff were also asked to inform patients of any delays when they booked in. We observed that patients were kept informed of clinic delays during our inspection.
- NHS Friends and Family Test questionnaires were available for patients in clinic waiting areas and we saw posters displayed, which encouraged patients to leave comments about the service. The response rate was poor with an average 4%, which was lower than the England average of 7%.
- Patients and relatives we spoke with were generally positive about the service and care they received in outpatients.

Staff engagement: Outpatients

- Outpatient and diagnostic services held regular team meetings, which all staff were invited to attend. Minutes were emailed to staff that were unable to attend meetings. Staff we spoke to said they felt informed of plans for outpatient services and were encouraged to share ideas of how to improve the services.
- Staff were involved in the improvements plan for outpatients. The service held listening in action sessions in June 2016 and July 2016 with 40 staff who worked in the outpatients. Staff identified areas for improvement such as improving the environment and improving communication. These formed the improvement plan. Staff we spoke with told us they felt actively engaged and their views were reflected in the planning and delivery of services. Listening into Action (LiA) is a way of working designed to empower staff at all levels in identifying and driving through the changes and improvements they want to see most. The trust told us the aim was to change the way the trust worked, allowing everyone working at the trust to remove the barriers that get in the way of delivering quality for patients. LiA supported an aim of the trusts; strategy – to listen to what frustrates staff at work, what they would like to see improve and change, and how leaders can support, enable and 'unblock the way' for staff to make that change happen. All staff were encouraged to get involved.

Outpatients and diagnostic imaging

Staff engagement: Diagnostic imaging services

- Staff were working with aging equipment and they were concerned about their patients' safety. The aging equipment did little in the way to motivate staff to want to stay and it had impacted on staff recruitment. Radiology technology was rapidly advancing and staff wanted to work in departments where equipment was modern and also safe for them and patients.
- Some staff were being looked after by occupational health due to the mechanical issues with the aging equipment.
- The nuclear medicine department were a small team who informed us they got on well, there was good patient feedback and staff were given chance to undertake continued professional development.
- Recruitment was deemed to be improving, radiology were noticing though that refusals to allow staff car parking on site were causing retention issues.
- There were action plans in place to address the recruitment issues. For example, staff that were offered jobs were contacted as soon as possible, students were being offered jobs when they completed exams and placements.
- In CT staff felt that they were a good team who were very flexible, the CT lead told us they would like more administration time which currently was sporadic and there were policies and procedures that they cited as requiring review. The team told us once more staff had been training they would be released from clinical work to address the administration tasks.
- The CT lead was proud of their hardworking staff that were constantly challenged by the workload.
- CT staff felt there was a greater positivity since the new management structure was put into place, managers were more approachable and things were improving, morale was on the up and there appears to be a better atmosphere throughout the department.
- The increase in staffing had made people happier as there were less pressures and staff were beginning to feel more valued by departmental management, team leaders feel more empowered to make their own modality decisions
- There was a recent allied health professionals meeting led by NHS England held at the trust, however radiographers could not attend due to clinical pressures, staff were demoralised due to this and felt it unfair that there was no representation from the radiography profession.

Innovation, improvement and sustainability: Outpatients

- The outpatient department had agreed objectives and action plans in order to develop and improve service provision; these were detailed in the patient care improvement plan. Plans were related to improving the efficiency and effectiveness of the department and patient experience. We saw evidence that the trust had made some progress towards achieving its plans. For example environmental improvements, standardise information being available for patients and improved communication with people waiting in the clinics. The process was ongoing at the time of the inspection.
- The outpatient department trained staff to meet the demands of the service. For example, ophthalmology, radiology, cardiology, dermatology and rheumatology services had all invested in training staff in additional skills and competencies, in order to increase capacity and improve services for patients.

Innovation, improvement and sustainability: Diagnostic imaging services

- Following the enforcement action in July 2016, the reporting radiographer service had increased the amount of cold reporting sessions and was in the process of increasing the number of chest and abdomen plain film reporting sessions to 8 sessions a week through a new training post. This would improve the sustainability of the plain film reporting, helping to reduce the risk of a repeat of the reporting backlog experienced earlier in the year.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure patients' privacy, dignity and confidentiality is maintained at all times. For example, patients staying overnight in the gynaecology assessment unit.
- Ensure that patient documentation, including risk assessments, are always completed accurately and routinely to assess the health and safety of patients. This should include elderly patient risk assessments, dementia assessments, venous thromboembolism assessments, sepsis bundle assessments and fluid balance charts.
- Use a standard risk assessment to assess and identify the needs of patients admitted to wards with mental health needs. This must include details of whether the patient requires 1:1 or 2:1 care from a specialist mental health nurse, and the level of care provided.
- Ensure nursing documentation on high dependency units is contemporaneous with detailed accounts of the day's activities completed.
- Ensure that patient weights are recorded on their drug charts.
- Ensure that there is clear oversight of the deterioration of patients and the National Early Warning Score chart is completed accurately.
- Ensure that the Paediatric Early Warning Score charts are consistently completed in a timely manner and accurately.
- Ensure that patients are escalated as a result of the Paediatric Early Warning Score where they trigger a deteriorating patient.
- Ensure that the eligibility criteria for the clinical decisions unit is followed to ensure appropriate patients are admitted.
- Ensure there is access to 24-hour interventional radiology services.
- Ensure staff are aware of ligature points.
- Establish identification of female genital mutilation training that is to be completed by all staff working in children and young people's services.
- Ensure that patients under child and adolescent mental health services receive care from appropriately trained staff at all times.
- Ensure that staff providing care for children requiring continuous positive air pressure or AIRvlo have appropriate training or up to date competencies to use this equipment safely.
- Ensure that there is an appropriate mental health room in the emergency department to care for patients presenting with mental health conditions that complies with national guidance.
- Ensure that flow in the hospital is maintained to prevent patients being treated in the emergency department corridors for extended periods of time.
- Ensure that children are not left unattended in the emergency department paediatric area.
- Ensure that there is a robust system in place to make sure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that equipment is checked as per policy, particularly in midwifery services.
- Ensure that patients are cared for in a safe environment that has the appropriate equipment to facilitate care to a deteriorating patient.
- Ensure that medicines are always stored within the recommended temperature ranges to ensure their efficacy or safety.
- Ensure prompt investigation of any medcines which are unaccounted for.
- Review arrangements around storage of intravenous fluids for emergency use to ensure patient safety.
- Ensure that medicines are always administered to patients as prescribed.
- Ensure infection prevention and control procedures are always carried out as per trust policy and national guidelines.
- Improve performance against the 18 week referral to treatment time, with the aim of meeting the trust target.
- Improve performance against the national standard for cancer waiting times. This includes patients with suspected cancer being seen within two weeks and a two-week wait for symptomatic breast patients.
- Ensure they are carrying out patient harm reviews to mitigate risks to patients who breach the referral to treatment times and cancer waits.
- Ensure safeguarding checks are made consistently.

Outstanding practice and areas for improvement

- Ensure information relating to the children at risk register is accessible.
- Ensure that incidents are accurately reported and investigated.
- Ensure that staff receive appropriate training to enable the correct categorising of incidents.
- Ensure that staff are not discouraged from reporting incidents relating to capacity and corridor care.
- Ensure that incidents that need reporting to external authorities are completed.
- Ensure there is an embedded risk assessment process to determine the criteria for patient moves to non-medical wards.
- Ensure all mortality and morbidity meetings are recorded and lessons are learnt.
- Ensure there are systems and processes established in surgical service to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.
- Ensure divisional management teams are aware of patient harm reviews to mitigate risks to patients who breach the referral to treatment times and cancer waits.
- Ensure divisional management teams have oversight of the patient waiting lists and of initiatives and actions taken to address referral to treatment times and cancer waits.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Develop a clearly defined business plan for paediatrics, which considers the risks to the service and incorporates a vision and plans for service improvement. The plan must have clear objectives and milestones, supported by actions to ensure objectives are realised.
- Ensure the risk register identifies and mitigates all risks.
- Ensure there is a review of the paediatric assessment area and subsequent admissions to identify and resolve potential issues with flow and capacity.
- Ensure the bed management plans for children and young people, devised to deal with escalation issues for staffing shortages or high bed occupancy, is up to date.
- Ensure there is a strategy is in place for diagnostic and imaging services that staff are aware of.
- Ensure patient notes are stored securely and safely.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets the trust target of 90%.
- Ensure all staff receive an annual appraisal.
- Ensure there are sufficient registered children's nurses in post to make certain that the emergency department has at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments.
- Ensure that only an appropriately trained staff member is left in charge of a ward to care for patients.
- Ensure lessons learned from incidents are shared.
- Ensure all equipment is in date and fit for purpose.
- Ensure that staff follow the policy on the use of the 'I am clean stickers', particularly in the emergency department.
- Ensure that all needles and cleaning chemicals are kept securely.
- All departmental policies and procedures, including safeguarding policies, should be reviewed and revised to ensure they are reflective of up to date guidance.
- Ensure that standard operating procedures are in place and are correctly followed, including care of patients within the clinical decisions unit and care of patients within the emergency department corridor.
- Ensure staff are familiar with the major incident policy and undertake specific training or complete exercises.
- Ensure that staff are aware of the escalation policies in the trust and were clear on what steps should or be taken during times of increased demand in the emergency department.
- Ensure that staff are aware of how to use panic buttons or what response would be received.
- Ensure that the emergency department door which ambulance patients are bought in by is not used as a shortcut for other staff.
- Ensure there is evidence of mitigating actions taken at trust wide and divisional level to significantly improve the care and environment in the emergency department to ensure patients are safe.
- Review the agency induction proforma.
- Ensure NHS Safety Thermometer data is displayed.
- Ensure that all medical patients have a nominated medical consultant allocated prior to discharge.

Outstanding practice and areas for improvement

- Review the staffing levels within diagnostic and imagining ensuring adequate cover for the demands for the service, supervision of staff and suitable radiation protection supervisor cover across all sites.
- Improve the process of review and document control of protocols for standard x-ray examinations.
- Develop a clinical audit plan that includes local priorities and audits completed on a timely basis. This should include clinical audits that meet the requirements of Ionising Radiation (Medical Exposure) Regulations 2000.
- Ensure action plans include sufficient detail to address identified concerns.
- Share results and action plans from national audits with all levels of staff to improve patient outcomes.
- The maternity service should conduct audits of the care of women with termination of pregnancies and the completion of their maternal early warning score; Worcestershire Obstetric Warning score.
- Ensure that all cardiotocograph traces have evidence of fresh eye reviews every two hours.
- Ensure that patients receive pain relief in a timely way.
- Ensure that patients are appropriately assessed to have a Deprivation of Liberty Safeguard implemented, where required.
- Ensure that additional steps are taken to maintain patients' privacy and dignity when nursed in mixed sex areas and during nursing handovers.
- Provide a follow up service for patients discharged from critical care with access to consultant and nurses.
- Review the choices offered to patients about where they are discharged to for continuing care.
- Reduce the number of cancelled of operations in line with the national average of 6%.
- Review the high levels of unplanned medical admission onto surgical wards, resulting in some cancelled operations.
- Put arrangements in place to limit the number of gynaecology patients being nursed on general wards.
- Review the capacity in emergency theatres.
- Ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for emergency departments.
- Ensure delays in ambulance handover times are reduced to meet the national targets.
- Ensure initial patient treatment times are reduced to meet the national target for 95% of patients attending the emergency department to be admitted, discharged or transferred within four hours.
- Ensure paediatric patients are directed to the paediatric waiting area in the emergency department.
- Ensure there are appropriate waiting room and toilet facilities for patients using the gynaecology assessment unit.
- Ensure there are clear pathways in place to support patients with complex needs, such as a learning disability and patients living with dementia, particularly within the emergency department, gynaecology and maternity.
- Ensure that staff are aware of how to access full patient information leaflets in an alternate language other than English.
- Ensure that all complaints are responded to in line with the trust policy.
- Ensure that health and wellbeing of staff is promoted, including encouragement to take their allocated breaks, particularly in the emergency department.
- Ensure that staff have an awareness of the trust's strategy.
- Ensure that senior trust wide leaders have an accurate overview of the care and environment in the emergency department.
- Ensure there is radiology representation at divisional level.
- Review the radiation protection governance and infrastructure to ensure compliance with statutory radiation regulations.
- Consider involving staff in strategic plans and developments within surgical services.
- Ensure visibility of the executive team.
- Develop a strategy to monitor the implementation of the gynaecology vision.
- Undertake a ligature audit in the paediatric department.
- Improve the process of risk rating and replacement of diagnostic and imaging equipment.
- Ensure there are consistent mortality review group meetings in order to review the Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator across the service.

Action the hospital SHOULD take to improve

- Ensure lessons learned from incidents are shared.

Outstanding practice and areas for improvement

- Ensure all equipment is in date and fit for purpose.
- Ensure that staff follow the policy on the use of the 'I am clean stickers', particularly in the emergency department.
- Ensure that all needles and cleaning chemicals are kept securely.
- All departmental policies and procedures, including safeguarding policies, should be reviewed and revised to ensure they are reflective of up to date guidance.
- Ensure that standard operating procedures are in place and are correctly followed, including care of patients within the clinical decisions unit and care of patients within the emergency department corridor.
- Ensure staff are familiar with the major incident policy and undertake specific training or complete exercises.
- Ensure that staff are aware of the escalation policies in the trust and were clear on what steps should or be taken during times of increased demand in the emergency department.
- Ensure that staff are aware of how to use panic buttons or what response would be received.
- Ensure that the emergency department door which ambulance patients are bought in by is not used as a shortcut for other staff.
- Ensure there is evidence of mitigating actions taken at trust wide and divisional level to significantly improve the care and environment in the emergency department to ensure patients are safe.
- Review the agency induction proforma.
- Ensure NHS Safety Thermometer data is displayed.
- Ensure that all medical patients have a nominated medical consultant allocated prior to discharge.
- Review the staffing levels within diagnostic and imagining ensuring adequate cover for the demands for the service, supervision of staff and suitable radiation protection supervisor cover across all sites.
- Improve the process of review and document control of protocols for standard x-ray examinations.
- Develop a clinical audit plan that includes local priorities and audits completed on a timely basis. This should include clinical audits that meet the requirements of Ionising Radiation (Medical Exposure) Regulations 2000.
- Ensure action plans include sufficient detail to address identified concerns.
- Share results and action plans from national audits with all levels of staff to improve patient outcomes.
- The maternity service should conduct audits of the care of women with termination of pregnancies and the completion of their maternal early warning score; Worcestershire Obstetric Warning score.
- Ensure that all cardiotocograph traces have evidence of fresh eye reviews every two hours.
- Ensure that patients receive pain relief in a timely way.
- Ensure that patients are appropriately assessed to have a Deprivation of Liberty Safeguard implemented, where required.
- Ensure that additional steps are taken to maintain patients' privacy and dignity when nursed in mixed sex areas and during nursing handovers.
- Provide a follow up service for patients discharged from critical care with access to consultant and nurses.
- Review the choices offered to patients about where they are discharged to for continuing care.
- Reduce the number of cancelled of operations in line with the national average of 6%.
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- Ensure paediatric patients are directed to the paediatric waiting area in the emergency department.
- Ensure there are appropriate waiting room and toilet facilities for patients using the gynaecology assessment unit.
- Ensure there are clear pathways in place to support patients with complex needs, such as a learning disability and patients living with dementia, particularly within the emergency department, gynaecology and maternity.
- Ensure that staff are aware of how to access full patient information leaflets in an alternate language other than English.

Outstanding practice and areas for improvement

- Ensure that all complaints are responded to in line with the trust policy.
- Ensure that health and wellbeing of staff is promoted, including encouragement to take their allocated breaks, particularly in the emergency department.
- Ensure that staff have an awareness of the trust's strategy.
- Ensure that senior trust wide leaders have an accurate overview of the care and environment in the emergency department.
- Ensure there is radiology representation at divisional level.
- Review the radiation protection governance and infrastructure to ensure compliance with statutory radiation regulations.
- Consider involving staff in strategic plans and developments within surgical services.
- Ensure visibility of the executive team.
- Develop a strategy to monitor the implementation of the gynaecology vision.
- Undertake a ligature audit in the paediatric department.
- Improve the process of risk rating and replacement of diagnostic and imaging equipment.
- Ensure there are consistent mortality review group meetings in order to review the Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator across the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 1. Service users must be treated with dignity and respect. 2. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— A. ensuring the privacy of the service user; **How the regulation was not being met:** • The hospital did not ensure that patient privacy, dignity and confidentiality were maintained at all times. • Gynaecology patients were not always treated in an environment that always maintained their dignity. • Patients stayed overnight on trolleys in the gynaecology assessment unit, which was an outpatient clinic area. There was no shower in the unit and the toilet facilities were mixed sex.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of service users of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks;

Requirement notices

C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
D. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
E. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;
F. the proper and safe management of medicines;
G. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;
H. where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

How the regulation was not being met:

- **Patient documentation, including risk assessments, were not always completed accurately or routinely to assess the health and safety of patients. These included elderly patient risk assessments, dementia assessments, venous thromboembolism assessments, sepsis bundle assessments and fluid balance charts. We found this occurred in various hospital services including the emergency department, medicine, surgery, critical care.**
- **Risk assessments were not undertaken for patients with mental health needs and 1:1 care from a suitably trained professional was not always provided.**
- **Nursing documentation on both high dependency units was not found to be contemporaneous with detailed accounts of the day's activities being completed at end of working shift.**
- **Patient weights were not recorded on their drug charts.**

This section is primarily information for the provider

Requirement notices

- **There was no clear oversight of the deterioration of patients. The National Early Warning Score (NEWS) chart was not completed in full. NEWS total score was not completed in seven out of 23 notes reviewed on medical wards.**
- **Paediatric Early Warning Score (PEWS) charts were not consistently completed in a timely manner or accurately. From trust's November 2016 audit of PEWs, 20% had a score of 3 or higher that had not been escalated.**
- **Medical outliers were sent to any ward where a bed was available without the move being risk assessed.**
- **The eligibility criteria for the clinical decision unit (CDU) was not routinely followed, resulting in patients that required care elsewhere in the hospital waiting on CDU. Out of eight patients only two met the criteria for CDU during inspection.**
- **The hospital did not have access to 24 hour interventional radiology.**
- **Staff were not always aware of ligature points.**
- **Training on female genital mutilation had not been established or completed by all staff who worked within children and young people's services.**
- **One patient under child and adolescent mental health services who required one to one care, received care from a health care assistant after a registered mental health nurse failed to turn up for the shift. Paediatric ward staff, including health care assistants had not received any training in mental health.**
- **Some staff providing care for children requiring continuous positive air pressure or AIRvlo did not have appropriate training or up to date competencies to use this equipment safely. This meant a delay of three hours for one child to receive this treatment.**
- **There was not an appropriate mental health room in the emergency department to care for patients presenting with mental health conditions. There was a room that complied with some of the national guidance but furniture was not secured, there were ligature points and exits were not clear from obstacles. Patients were not cared for in this**

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room and they were rotated in and out. Patients with mental health conditions (both adults/ paediatrics) were cared for in the main emergency department with other patients. Risk assessments were carried out on all patients presenting with mental health conditions however, even if high risk this did not change where the patient was cared for.

- **Patients were cared for in the emergency department corridors for extended periods of time (during inspection some over 22 hours) due to lack of flow out of the department.**
- **Children were left unattended in the emergency department paediatric area.**
- **There was not a robust system in place to ensure that all electrical equipment had been safety checked yearly. Unchecked equipment was found in the delivery suite and the birth centre**
- **The emergency neonatal trolley in the delivery suite was not always checked daily as per policy.**
- **Medical outliers were not always cared for in a safe environment that was fully equipped with resuscitation trolleys to cater for deteriorating patients. For example, the theatre assessment unit did not have the appropriate equipment, such as a resuscitation trolley, to facilitate care to a deteriorating patient.**
- **Medications were not always stored within the recommended temperature ranges to ensure their efficacy or safety.**
- **Medicines which could not be accounted for were not investigated promptly.**
- **Intravenous fluids for emergency use were stored in emergency trolleys which were not tamper evident.**
- **Medicines were not always administered to patients as prescribed. Patients with Parkinson's disease and diabetes did not always receive their doses of time critical medicines on time whilst being cared for in the emergency department corridor.**
- **Infection prevention and control procedures were not always carried out as per trust policy and national guidelines.**

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- **Not all staff adhered to the infection control policies with regards to hand hygiene and the use of personal protective equipment, particularly in surgical services and critical care. For example, doctors were not always 'bare below the elbow'.**
- **Appropriate infection control procedures were not being adhered to for patients with infectious diseases who required barrier nursing.**
- **The hospital was not achieving the trusts target for referral to treatment time (RTT) for surgical services. RTT for surgery was worse than the England average.**
- **The hospital was not achieving the cancer 62 day wait national target of 85% (66% in July 2016).**
- **The hospital was not achieving the cancer two week wait national target 93% (July 2016 74.5% with 28 breaches, year to date performance 45%).**
- **There is a risk that patients may have suffered harm due to the long waits, i.e. preventable potential deterioration to their condition. Staff we spoke with, including executives were unable to provide assurance that harm reviews for patients on the waiting list were being carried out. We asked the trust for assurance that harm that there was a process in place to assess this risk, however, the trust have not provided us with a response. The RTT is likely to deteriorate further due to cancellation of elective work until 16 January 2017.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. 2. Systems and processes must be established and operated effectively to prevent abuse of service users. 3. For the purposes of this regulation—'abuse' means—

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A. any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
B. ill-treatment (whether of a physical or psychological nature) of a service user,
C. theft, misuse or misappropriation of money or property belonging to a service user, or
D. neglect of a service user.

How the regulation was not being met:

- Safeguarding checks were not undertaken consistently.
- Information relating to the children at risk register was not always accessible. Children were not flagged on arrival to the emergency department. Information was in a book contained within a triage room. If this room was in use the book was, at times, inaccessible.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; C. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

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D. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

How the regulation was not being met:

- Staff in the emergency department were discouraged to report incidents relating to high capacity and care in the corridor. We saw evidence via an email to support this. There was a risk that staff would stop reporting safety and capacity incidents.
- The critical care service did not always report patient incidents correctly, categorising them as near misses or as an internal incident only.
- Not all incidents that would be externally reportable as 'serious', were classified correctly and reported in critical care.
- There was no embedded process to determine the criteria for patient moves.
- Perinatal mortality and morbidity meetings were not always recorded and those that were had no evidence of learning or further actions.
- The hospital had not ensured systems and processes were established and operated effectively in the surgical service. The hospital did not have robust action plans in place to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.
- The divisional management team did not appear to have oversight of, or were aware of any initiatives undertaken to reduce referral to treatment times/ cancer waits and mitigate risk to patients on waiting lists.
- There was no clear strategy for a county wide surgical service, especially for the management of emergency surgery.
- The business plan lacked detail and failed to consider the vision or the service as well as the risks it faced. Clear objectives and not been set and were not supported by milestones and actions.
- The risk register failed to identify all risks faced by the hospital.
- There had not been a review of the paediatric assessment area and subsequent admissions to identify potential issues with flow and capacity.

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- The bed management plans for children and young people devised to deal with escalation issues for staffing shortages or high bed occupancy had not been revised since the reconfiguration had taken place. Mitigation plans therefore, were out of date.
- The divisional management team were unable to describe the strategy for outpatients and diagnostic imaging and told us that a strategy was not expected until next year.
- Medical records were not always stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2. Persons employed by the service provider in the provision of a regulated activity must— A. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, B. be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and **How the regulation was not being met:** • Not all staff had the correct level of safeguarding training to enable them to carry out the duties they are employed to perform. • The level of safeguarding children's training that staff in certain roles received was not compliant with intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) particularly in the emergency department, midwifery department and theatres. • The provider had not ensured staff received mandatory training and appraisals to provide safe and effective care. Compliance with mandatory training and appraisals did not meet the trust target.

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- There were insufficient registered children's nurses in post to ensure that the emergency department had at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments. Only one nurse was allocated for each shift to oversee the paediatric area. To mitigate risks where possible, 10 adult nursing staff had attended a course at the local university to complete to paediatric competencies.
- The clinical decision unit was staffed by one registered nurse and one health care assistant per shift. When the registered nurse went on break the area was covered by only the health care assistant, caring for eight patients. Health care assistants did not have the appropriate training necessary to enable them to care for patients autonomously on a ward.